907 KAR 1:705

Demonstration Project: Services Provided Through Regional Managed Care Partnerships (1115 Waiver)

"Incorporated by Reference Material

dated January 1, 1997"

CHAPTER 1

WHAT HEDIS IS

and Why We Need It

HEDIS 3.0 is a giant step forward in the nation's effort to develop a standard set of measures that will give purchasers and consumers the ability to assess the value of the increasingly costly health care services they buy and use. At a time of political gridlock and an era of rampant discord, a broadly constituted committee representing different and often competing interests achieved consensus across a broad range of issues. The product of this consensus — HEDIS 3.0 — is a set of performance measures of unprecedented scope and reach. It is also a process for the continued enhancement of that set, through the systematic, open and rigorous solicitation and evaluation of the new measures the public will need as we move toward the 21st century.

In the chapters that follow, we will describe how HEDIS 3.0 came to be and the details of the measures that are included in it. You will learn how much effort went into its construction and how comprehensive is the result. In the remaining sections of this chapter, we'd like to provide some context for HEDIS 3.0 — to help you understand why that level of effort was required and why the result is so important.

WHAT IS HEDIS?

HEDIS — the Health Plan Employer Data and Information Set — is a set of standardized performance measures, designed to ensure that the public has the information it needs to reliably compare the performance of managed health care plans. The development of HEDIS was sponsored and staffed by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to evaluating and reporting on the quality of managed care plans.

NCQA's primary objective is to develop strategies and systems to establish accountability in the managed care industry. HEDIS is one component of a larger accountability system. HEDIS is about the results that health plans achieve. It operates as a complement to NCQA's Accreditation program. NCQA Accreditation is a rigorous and expert evaluation of how managed care plans are organized and how they operate. In combination, the results from NCQA Accreditation and from HEDIS measurement provide the most complete view of health plan quality available to purchasers and consumers today. HEDIS 3.0 extends that view significantly beyond NCQA's earlier work.

WHY DO WE NEED HEDIS?

The past two decades have been years of extremely rapid increase in health care costs. As costs have increased, those who purchase health benefits — both the large corporations that purchase care on behalf of their employees and the public Medicare and Medicaid programs that purchase care on behalf of the senior population and the poor — have become increasingly concerned that the "value" of health care has not risen proportionately. As health benefits consume an ever-larger proportion of the expense sheet, these purchasers have sought means to assess the relative value of the care offered by the managed care health plans with which they contract. HEDIS offers that possibility. In addition, HEDIS helps purchasers and consumers distinguish among plans on the basis of comparative quality, instead of simply on cost differences.

HEDIS is a set of standardized measures that supports market-based reform in health care: If those who choose their health care plan do so based on demonstrated value, then the market will drive health plans to improve performance as well as to reduce cost. The result can be higher levels of quality, without excessive regulation that could limit innovation.

The value that HEDIS represents exists on two fronts. First, HEDIS measures give the public an unprecedented ability to understand how well health plans are achieving the results that matter — how effective and satisfying is the care and service delivered; how accessible is that care; how well is the plan equipping its members to make informed choices about their own health care; and so on. But just as important, HEDIS measures ensure that results will be comparable across health plans. Because HEDIS measures are defined with attention to detail — and because the development of HEDIS measures has taken advantage of the knowledge of those who understand health plan operations and health plan data systems — HEDIS measures are uniquely able to provide information that allows comparison.

Much of the work of developing HEDIS is "simply" the work of turning a straightforward concept (are children with asthma getting the care they need?) into a set of rules that can be unambiguously interpreted and consistently applied across health plans, and that account for differences in data systems (and in population risk) that might affect results independent of health plan performance. We have learned that this kind of translation is nowhere near as simple as it seems, and that without considerable attention to the operational details, conceptually attractive measures in fact offer no useful information. A considerable — and unique — component of the value of HEDIS is the extraordinary attention to these (and to other equally challenging) statistical details.

WHAT IS HEDIS 3.0?

HEDIS 3.0 is the third such set NCQA has produced. NCQA's first set — HEDIS 2.0 — was an enhancement of an earlier version (HEDIS 1.0) developed by a consortium of large corporations (Bull HN Information Systems, Inc., Digital Equipment Corporation, GTE and Xerox Corporation), Towers Perrin, and health plan representatives from The HMO Group (a coalition of group- and staff-model HMOs that organized the effort). HEDIS 2.0 was released in November 1993 and moved rapidly into the managed care marketplace. In 1996, more than 330 health plans are producing HEDIS statistics, and a majority of the large corporations that purchase managed care benefits are using HEDIS data to help guide their managed care purchasing decisions.

With the release of HEDIS 2.0, there was great interest in developing performance measures for publicly insured populations as well. With assistance from the Health Care Financing Administration (HCFA) and the American Public Welfare Association (APWA), NCQA organized a broadly constituted committee of representatives from state Medicaid programs, Medicaid advocacy groups, health plans and others with relevant expertise, and undertook to adapt the HEDIS 2.0 statistics for application to the Medicaid program. This work took nearly two years; the product of this "Medicaid Workgroup" (Medicaid HEDIS) was released in February 1996.

Medicaid HEDIS resembles HEDIS 2.0 quite closely; differences arise primarily from demographic differences in the Medicaid population (which is disproportionately composed of women of child-bearing age and young children) and from technical modifications to measures necessary to account for rapid turnover in the Medicaid population (less than half of Medicaid enrollees stay in a health plan for a year or more).

The demand for information relevant to the Medicare program, and useful to the senior population for whom Medicare operates, prompted discussion about the development of a set of performance measures for the Medicare risk population — a "Medicare HEDIS" — to supplement HEDIS 2.0 (which was renamed HEDIS 2.5 after a set of technical modifications in 1995) and the Medicaid set. Discussions among NCQA, the Health Care Financing Administration and the Kaiser Family Foundation, however, suggested that efforts to develop measures for the Medicare risk population should be folded into NCQA's planning for HEDIS 3.0, which was intended to be, from the outset, a performance measurement set made up of statistics that permitted integration of measurement across the public and private sectors.

Why were HEDIS 2.5 and Medicaid HEDIS brought together and a Medicare set developed as part of that integration? There are many reasons:

- It is extremely costly to develop and maintain the structures required to build performance measurement sets. A process for supporting a single, integrated set of measures is far more efficient to build and maintain than would be processes for multiple, independent sets.

- It can be highly burdensome for health plans to produce performance measures. A single set of measurement specifications that can be used for different populations is less costly for health plans than multiple specifications.
- There is more statistical power in evaluating a single (large) population than in evaluating smaller subpopulations. A single specification that permits data to be aggregated across populations (e.g., diabetic members insured under both commercial policies and Medicare) creates the potential for statistically more powerful measures.
- A single measurement specification used for different populations makes it possible to compare results not only across plans, but also across populations in a plan.

But the most compelling reason to develop a single set of measures has nothing to do with cost or statistical power. It follows from a basic philosophical tenet that underlies the planning for this work: **High quality care should be the same no matter who is paying for that care.** Women should receive mammograms when clinical circumstances require; breast cancer should be detected early no matter who is paying the bill. The objective of a single set of measures embodies the belief that health plans should be held accountable to the same standard of care for all patients; and that the standard should be dictated by medical science, not by insurance programs nor by patient circumstance. For a number of reasons, the CPM was unable to achieve full integration of the measurement set. However, the CPM expects full integration in the next 24 to 36 months.

THE REMAINDER OF THIS DOCUMENT

The remainder of the document will provide more details about HEDIS 3.0, beginning in the next chapter with the process that led to its construction. In Chapter 3, we describe the components of the set. Chapter 4 is a discussion of issues related to the interpretation and use of HEDIS 3.0 data, and Chapter 5 offers some thoughts about the future of HEDIS in particular and performance measurement in general.

Three appendices follow. The first is a series of acknowledgments of those individuals and organizations who volunteered their time and/or entered into other partnership with NCQA to make the development of HEDIS 3.0 possible. Appendix 2 is an acknowledgment of those many organizations and individuals who responded to our Public Call for Measures: those who provided the raw materials from which HEDIS 3.0 was built and who share in the authorship of this work. Appendix 3 provides a list of selected references used in the development of each HEDIS 3.0 measure.

CHAPTER 2

BUILDING HEDIS 3.0

HEDIS 3.0 was developed by a broad-based committee — the Committee on Performance Measurement. The CPM was organized and staffed by the National Committee for Quality Assurance (NCQA); funding for its work came from a wide variety of public and private sources. The members of the CPM were chosen to reflect the diversity of constituencies that performance measurement must serve: purchasers, both private and public (Medicare and Medicaid); consumers; organized labor; medical providers; public health officials, and health plans. In addition, a number of other individuals were asked to serve, to bring other important perspectives as well as additional expertise in the areas of quality management and the science of measurement.

STRATEGIC PLAN

The CPM began its work in September 1995. Its goal was to develop HEDIS 3.0 and manage the evolution of this standardized set of performance measures over time. Five priorities shaped its strategy:

- First, there was a need to begin to fill some of the gaps that had been identified since the release of HEDIS 2.0. There was a need for more measures related to acute and chronic illness, for measures that applied to populations other than the commercially insured (particularly Medicare), for measures that were more relevant to the consumers of health care, for measures that were more balanced with respect to the populations covered (e.g., conditions relevant to adult males were not as well addressed as adult females), and for measures that focused to a greater extent on the results that health plans achieve, rather than on the processes used to achieve them. There was also a commitment to begin to address some of the technical limitations of HEDIS 2.0 measures, particularly the absence of a strategy for adjusting for differences in the characteristics of the populations that health plans serve; differences that might affect measured results, but that were not related to health plan performance.
- Second, NCQA wanted to integrate the recently released Medicaid HEDIS measures into the broader measurement set. The Medicaid work had begun two years before the strategy envisioned for HEDIS 3.0. Given that the 3.0 set was to be expanded to the Medicare population as well, NCQA was concerned about the potential burden created by separate and possibly redundant measurement sets for each population. Moreover, if measurement was made consistent across

populations, comparisons could be more easily made. Thus, where appropriate, systems-based quality improvement activities could yield more powerful results for a greater number of members, more efficiently.

- Third, given the reach of HEDIS, it was clear that the process needed to include a broader range of "end-users" than had been previously involved. These included consumers, public health officials, measurement experts, unions and public purchasers. Incorporating these perspectives into the development of HEDIS 3.0 explicitly addressed the desire to expand its relevance beyond the privately insured, and to build an efficient process for meeting the diverse information needs of various users. A complete list of the 24-member CPM is found in the Acknowledgments section.

- Fourth, the field of performance measurement, while still young, is active — with significant work occurring in many different settings throughout the country, including research organizations, managed care plans, medical specialty societies, pharmaceutical research departments, health care institutions, and voluntary health organizations. Many of these efforts focus on levels of measurement other than the health plan itself. However, NCQA believed that the development of HEDIS 3.0 should attempt, wherever possible, to build on these efforts rather than to duplicate or ignore them. Thus, NCQA's strategy was to begin the process of evolving HEDIS by reaching out to bring in the best-available measures and by then assessing to what extent those measures were likely to meet the information needs of the public. By doing so, the Committee was not only able to leverage current work, but was also able to identify promising measures for "cultivation," and to identify areas in which focused research and development was needed to create measures for the future.

- Finally, the resources devoted to collecting and reporting HEDIS, its potential impact on employer and consumer decisions and the importance of measurement in setting the strategic direction of managed care organizations all emphasized the need to ensure that developers incorporate scientific rigor into their methods. In formulating the procedures for developing HEDIS 3.0, every reasonable effort was made to build in mechanisms that subjected proposed measures to a critical evaluation based on such criteria as relevance to users, scientific validity and operational feasibility.

Given its objectives — to develop a HEDIS that met the broad information needs of public and private payers and members and to develop a process to assure that future sets would continue to do so — the CPM began to map out its strategy for moving quickly toward those ends. An early commitment was to begin with the HEDIS measures that were already available — those developed for commercial enrollees (HEDIS 2.5) and those developed for the Medicaid program (Medicaid HEDIS). The CPM's strategy here was to integrate these measures into a single, non-duplicative set and then to expand those measures (where feasible and appropriate) to include the Medicare population as well. Thus, the platform from which HEDIS 3.0 was built were its predecessors — HEDIS 2.5 and Medicaid HEDIS — measures already in use in more than 330 health plans across the country.

It was clear from the beginning, however, that there were issues that were not adequately addressed by available HEDIS measures. At its first meeting, the CPM began to map out a strategy to develop additional measures — for HEDIS 3.0 and future generations of HEDIS as well. The CPM immediately recognized that the task of developing new measures was beyond its ability — that a Committee organized to manage the process of measures development could not possibly include all the knowledge required to build measures. More than that, the CPM recognized that the task of expanding HEDIS could best be accomplished by taking advantage of the collective knowledge and expertise of clinical and measurement experts across the country. As a result, it laid out an open process for developing measures: one that began with the CPM communicating to those outside of it the information that the public needed to assess the relative performance of health plans. It required, as well, that the CPM develop criteria to evaluate measures, to enable the Committee to systematically and objectively assess the extent to which measures brought to it responded to the needs the Committee had articulated.

EVALUATION OF NEW MEASURES

The CPM was fortunate to be able to draw upon the expertise and knowledge of so many individuals and organizations. To help members understand what information was important to purchasers and consumers, the Committee commissioned an expert subcommittee to prepare a report on the information needs of the Medicare program and its beneficiaries; it reviewed the work of NCQA's Medicaid Workgroup, which had produced Medicaid HEDIS; it commissioned a synthesis of available knowledge about how privately insured consumers make choices about health plans, and brought a number of experts in that field to its meetings, and it commissioned focus groups to assess consumer reaction to possible measures.

To help members understand the science and state of the art in performance measurement, the Committee organized a Technical Advisory Committee (TAC), and commissioned papers by leading experts in the field. These papers and the TAC brought unprecedented levels of science and evidence to the Committee's deliberations.

With these resources and NCQA staff support, the Committee set about first to try to understand the information needs to which HEDIS 3.0 had to respond and the characteristics (or "attributes") of measures that would make them useful to purchasers and consumers to assist in health plan selection. The Committee laid out eight "domains," or categories, which represent the broad areas in which results matter. (These domains are described in more detail in the next chapter.) These, the Committee decided, were the areas in which measures needed to focus:

Effectiveness of care: Is care achieving the gains in health expected?

Access/availability of care: Is care available to those who need it, without inappropriate barriers and delay?

Satisfaction with the experience of care: Is the experience of care satisfying, as well as clinically effective?

Cost of care: Is care high value?

Stability of the health plan: Is the health plan stable — or will I experience the sort of change that could disrupt my care?

Informed health care choices: Is the health plan successful at helping members to be active and informed partners in health care decisions?

Use of services: How are resources used? Is there evidence of too much — or too little — care?

Health plan descriptive information: How is the plan organized? What type of doctors participate, and how many?

In each of these domains, the CPM sought measures that would help purchasers and consumers compare health plans. The Committee thought long and hard about the characteristics of measures that would make them useful for such a purpose. With the assistance of TAC members, the Committee laid out a series of criteria that defined the attributes that it felt important for measures to possess in order to be included in HEDIS 3.0 and future generations of HEDIS. These attributes fell into three major categories:

Relevance. Measures had to be relevant to purchasers and/or consumers if they were to be considered for inclusion in HEDIS 3.0. Measures were relevant to the extent that they addressed issues that were known to significantly affect health outcomes, to the extent that those issues were controllable (or at least could significantly be influenced by) the health plan, to the extent that there was known or suspected significant differences between health plans (or between average performance and ideal performance) and to the extent that there was evidence that purchasers and/or consumers would use that information in selecting a health plan.

Scientific soundness. Measures had to be scientifically sound for the CPM to have confidence that the information produced through measurement would lead to better decisions. To be sound, the Committee sought measures that were reproducible (i.e., that produce the same results when repeated in the same populations and setting), valid (i.e., make sense logically and relate to other measures looking at the same aspect of care) and accurate (i.e., measure what is actually happening). Measures also had to have sufficient statistical power to detect differences of the magnitude expected between health plans (or the measures would not be useful for comparison) and had to include a strategy to adjust results for other factors (such as characteristics of the health plan population) that might lead to measured differences in health plan results.

Feasibility. The CPM was interested in producing a measurement set that was useful in 1996. While it was unwilling to be tightly bound by the limitations of current information systems — an explicit objective of the CPM was to use HEDIS measures to stimulate improvements in those information systems — it was also clear that those potential HEDIS measures that were easy to produce would be of most value in the short run. In order to be feasible, a measure needed to be clearly specified (and specified in a manner that could be calculated with data that might be available), it had to be possible to produce the measure at a reasonable cost and the collection of data for the measurement could not threaten the confidentiality of any patient information.

The CPM recognized that few available measures were likely to have all of these attributes to the extent desired, but agreed that the long-term requirements for HEDIS measures should be established and communicated as early as possible. More than that, the Committee used these attributes to guide its evaluation of potential HEDIS measures and to identify issues that could be resolved empirically where measures fell far short.

The domains and attributes were summarized in the CPM's December 1995 "Public Call for Measures." That solicitation of input was mailed to more than 1,700 organizations; hundreds more obtained it via the Internet. By March 1996, 826 measures (in various stages of development) had been submitted to NCQA.

Over the next three months, these measures were evaluated by NCQA staff, by a multi-disciplinary review team of 17 experts (including members of the CPM and TAC, but also individuals involved in the development of earlier versions of HEDIS and experts from outside the process) and by the CPM itself. The review team (and a second special panel, constituted to review measures in the area of behavioral health) used multi-voting processes to choose subsets of the most promising measures.

These relatively smaller sets of measures were exhaustively "worked up" by experts in the fields relevant to their analysis. Again, the CPM was fortunate to be able to draw upon the very best scientific resources: the U.S. Centers for Disease Control and Prevention (CDC), the Agency for Health Care Policy and Research (AHCPR), the Health Care Financing Administration (HCFA) and the RAND Corporation, as well as a number of individuals (acknowledged elsewhere) who are, without question, among the leaders in their fields. In addition, the HEDIS Users Group — primarily a group of health plans that have worked with NCQA to improve earlier HEDIS measures — provided invaluable assistance developing the detailed specifications for potential measures. Work-ups analyzed available evidence relevant to each of the attributes important to the CPM; these analyses were summarized in 10- to 30- page papers that CPM members read before meetings. At the final CPM meetings, measures were voted into HEDIS 3.0. New measures that were felt to possess important attributes to the extent necessary were voted into the set of measures to be made the new national reporting standard. Descriptions of these measures are in the next chapter, and detailed specifications are included in Volume 2.

There were a number of new measures that addressed very important issues, but for which available evidence and expert judgment raised significant concerns about the measures' scientific soundness or feasibility. The Committee had vigorous (and often passionate) debate about these measures — trying to determine the right balance between the need to respond to the urgent demand for information on critically important issues and the need to prevent the diversion of precious resources into the collection of data that might produce invalid information. The CPM realized that some of the things we might hope to measure are simply not measurable right now. But it also realized that — by taking an active role in developing new measures — its process could accelerate the rate at which knowledge is gained.

BALANCING A PERFORMANCE MEASUREMENT SET

The Committee chose to create a new element of HEDIS: a set of promising measures that address important issues but are as yet "immature," and that will be tested and refined under the CPM's direction. This "Testing Set" is one of the ways that the CPM hopes to facilitate the development of the measures that are needed to close remaining gaps in HEDIS; it is a "garden" of measures that will — as it matures — feed subsequent generations of HEDIS. Descriptions of these measures (with some of the outstanding issues that need to be addressed) are also in the next chapter, but specifications for Testing Set measures are **not** included in Volume 2.

As the CPM was considering the addition of new measures, it also considered whether measures from earlier versions of HEDIS were still necessary. In fact, several measures were retired — either because clearly superior measures came to light that made older measures redundant, because experience had established that these measures were not sound or not feasible or because the marginal value associated with a measure seemed small relative to the burden associated with it.

In addition to removing specific measures from the Reporting Set, the CPM also identified a number of strategies that could be implemented to assure that full compliance with HEDIS was within the financial and logistical reach of both large and small health plans. The CPM solicited comments during a 45-day comment period regarding how to make the transition to HEDIS 3.0. Comments from 300 organizations were received and were summarized for review by the CPM.

On September 25 and 26, 1996, the CPM met to consider these comments and to make final changes to the measurement set. One fundamental clarification involved the time-frame over which the transition to HEDIS 3.0 from earlier versions of HEDIS reporting will be expected. In short, for the Effectiveness of Care, Health Plan Stability, Cost of Care, Informed Health Care Choices and Health Plan Descriptive Information domains, all HEDIS 3.0 measures are required for all populations to which they are applicable in **Reporting Year 1996** (data to be reported in 1997). For the Use of Services and Access/Availability of Care domains, measures that originated in HEDIS 2.5 will be upgraded to 3.0 specifications and applicable to the appropriate populations in **Reporting Year 1996**, and measures that originated in Medicaid HEDIS will be upgraded to HEDIS 3.0 specifications but applicable only to the Medicaid populations until **Reporting Year 1997** (data reported in 1998). Health plans should be prepared to report their HEDIS information to external requesters by June 1, 1997. Refer to the Reporting Year 1996 and Reporting Year 1997 matrices in *Volume 2: Technical Specifications* for more detailed instructions.

CHAPTER 3

THE HEDIS DOMAINS

and Descriptions of the Measures

In this chapter, we describe the eight general areas, or domains, in which HEDIS provides information and the measures that constitute each domain. Two kinds of measures are described: those in the HEDIS 3.0 Reporting Set and those in the HEDIS 3.0 Testing Set.

Health plans are expected to provide information on measures in the Reporting Set. Instructions for calculating the Reporting Set measures are in Volume 2. Health plans will not be able to provide information on Testing Set measures; NCQA will collaborate with researchers, health plans and purchasers to resolve any issues with these measures, so that the research questions can be answered as soon as possible. We include them in this document to offer health plans a "heads up" and to give consumers, purchasers and others a preview of the information we hope to make available to them in the future. Within the description of each Testing Set measure is a brief list some of the issues to be tested. As the testing of measures will be comprehensive, this list of issues to be tested is not meant to be exhaustive; rather, it is intended to give a sense of the important questions and issues surrounding each measure.

This chapter provides some guidance regarding use of HEDIS information for assessing health plan performance. Please note that each measure may or may not be applicable to each of the three populations assessed by HEDIS (those covered by Medicaid, those commercially insured, and those covered by Medicare); the specifications for each Reporting Set measure (in Volume 2) indicate to which populations the measure applies.

HEDIS 3.0 REPORTING SET MEASURES

Effectiveness of Care

Childhood Immunization Status

Adolescent Immunization Status

Advising Smokers to Quit

Flu Shots for Older Adults

Breast Cancer Screening

Cervical Cancer Screening

Prenatal Care in the First Trimester

Low Birth-Weight Babies

Check-Ups After Delivery

Treating Children's Ear Infections

Beta Blocker Treatment After a Heart Attack

Eye Exams for People with Diabetes

The Health of Seniors

Follow-Up After Hospitalization for Selected Mental Illnesses

Access/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

Children's Access to Primary Care Providers

Availability of Primary Care Providers

Availability of Mental Health/Chemical Dependency Providers

Availability of Obstetrical and Prenatal Care Providers

Initiation of Prenatal Care

Low Birth-Weight Deliveries at Facilities for High-Risk Deliveries and Neonates

Annual Dental Visit

Availability of Dentists

Availability of Language Interpretation Services

Satisfaction with the Experience of Care

- Member Satisfaction Survey
- Survey Descriptive Information

Health Plan Stability

- Disenrollment
- Provider Turnover
- Years in Business/Total Membership
- Indicators of Financial Stability
- Narrative Information on Rate Trends, Financial Stability and Insolvency Protection

Use of Services

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth And Sixth Years of Life
- Adolescent Well-Care Visit
- Frequency of Selected Procedures
- Inpatient Utilization — General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization — Nonacute Care
- Discharge and Average Length of Stay — Maternity Care
- Cesarean Section and Vaginal Birth After Cesarean (VBAC-Rate)
- Births and Average Length of Stay, Newborns
- Mental Health Utilization — Inpatient Discharges and Average Length of Stay
- Mental Health Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
- Readmission for Selected Mental Health Disorders
- Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
- Readmission for Chemical Dependency
- Outpatient Drug Utilization

Cost of Care

Rate Trends

High-Occurrence/High-Cost DRGs

Informed Health Care Choices

New Member Orientation/Education

Language Translation Services

Health Plan Descriptive Information

Board Certification/Residency Completion

Provider Compensation

Physicians Under Capitation

Case Management

Utilization Management

Risk Management

Quality Assessment and Improvement

Recredentialing

Preventive Care and Health Promotion

Arrangements with Public Health, Educational and Social Service Organizations

Pediatric Mental Health Services

Chemical Dependency Services

Family Planning Services

Total Enrollment

Enrollment by Payer

Unduplicated Count of Medicaid Members

Diversity of Medicaid Membership

Weeks of Pregnancy at Time of Enrollment in the Health Plan

HEDIS 3.0 TESTING SET MEASURES

Effectiveness of Care

Substance Counseling for Adolescents

Number of People in the Plan Who Smoke

Smokers Who Quit

Flu Shots for High-Risk Adults

Stage at Which Breast Cancer Was Detected

Chlamydia Screening

Colorectal Cancer Screening

Aspirin Treatment After a Heart Attack

Follow-Up After an Abnormal Pap Smear

Follow-Up After an Abnormal Mammogram

Use of Appropriate Medications for People with Asthma

Monitoring Diabetes Patients

Prevention of Stroke in People with Atrial Fibrillation

Outpatient Care of Patients Hospitalized for Heart Failure

Cholesterol Management of Patients Hospitalized for Coronary Artery Disease

Controlling High Blood Pressure

Assessment of How Breast Cancer Therapy Affects the Patient's Ability to Function

Prescription of Antibiotics for the Prevention of HIV-Related Pneumonia

Screening for Chemical Dependency

Continuity of Care for Substance Abuse Patients

Failure of Substance Abuse Treatment

Continuation of Depression Treatment

Availability of Medication Management and Psychotherapy for Patients with Schizophrenia

Appropriate Use of Psychotherapeutic Medications

Family Visits for Children Undergoing Mental Health Treatment

Patient Satisfaction with Mental Health Care

Access/Availability of Care

Problems with Obtaining Care

Satisfaction with the Experience of Care

Consumer Assessments of Health Plans Study (CAHPS)

Disenrollment Survey

Satisfaction with Breast Cancer Treatment

Use of Services

Use of Behavioral Health Services

Cost of Care

Health Plan Costs Per Member Per Month

Informed Health Care Choices

Counseling Women About Hormone Replacement Therapy

EFFECTIVENESS OF CARE

When comparing health plans, most people want to know how well the plans treat their members' medical problems. Information about the clinical quality of health care actually delivered by health plans has long been elusive, leaving consumers and purchasers to rely on the anecdotal opinions of others or the unsubstantiated claims of the plans themselves.

Effectiveness of Care measures generally look at the impact of care delivered to certain populations enrolled in a health plan. In most cases, the measured impact is positive, and the higher the score on a measure the better. For example, in a measure on treatment for patients who have had a heart attack, one would look for a high score indicating that the plan took certain clinical actions to help reduce the chances that another heart attack will occur. Of course, some people enrolled in health plans are sicker than others, which makes it more difficult to measure clinical quality. Measurement strategies need to incorporate mechanisms to adjust for these differences in patient populations (taking these factors into account when reporting statistics is referred to as "risk adjustment").

Measures in the Effectiveness of Care domain give consumers and purchasers important information about the quality of the clinical care provided by different plans. The measures have been grouped by the type of care they address (preventive, early detection and screening, maternity, acute, chronic and behavioral health), and the population of concern (children, adolescents, adults, and seniors). They take into account how well the plan incorporates widely accepted preventive practices (such as childhood immunizations), recommended screenings for common diseases (like breast and cervical cancer) and treatment for pregnant women (such as prenatal care in the first trimester) into the health care it provides. Effectiveness of Care measures also help consumers compare how plans are treating members who are already ill (for example, patients who have had a heart attack or children with ear infections) as well as those who have chronic diseases (such as asthma and diabetes) that need to be managed in order to avoid or minimize complications.

For some of the measures, we have been able to provide the performance goals in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, which was issues by the Public Health Service in 1990 and updated in 1995.

Keeping People Healthy: Health Maintenance and Disease Prevention

CHILDREN

Childhood Immunization Status

Childhood immunizations help prevent serious illnesses, such as polio, tetanus, whooping cough and meningitis. Vaccines are an easy, proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases such as the mumps and measles. The Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians and Advisory Committee on Immunization Practices all recommend that by their second year of life, children should have received four shots of DTP (diphtheria-tetanus-pertussis), three

OPV/IPV (oral or injectable polio virus) vaccines, one dose of MMR (measles-mumps-rubella) vaccine, a minimum of three Hib (Haemophilus influenza type B) vaccines, and three HepB (hepatitis B) vaccines. The *Healthy People 2000* goal is to increase to 90% the proportion of children up to 2 years of age who are fully immunized.

This measure estimates the percentage of children in the plan who received the appropriate immunizations by their second birthday. ***This measure is required for reporting.***

ADOLESCENTS

Adolescent Immunization Status

Immunizations are a proven defense against serious illnesses, such as hepatitis B, polio, tetanus and diphtheria, so health plans should help ensure that adolescents are vaccinated according to schedule. Experts in the field recommend that by the time children are 13 years old, they should have received the following immunizations: MMR-2 (second dose of measles-mumps-rubella), HepB (hepatitis B), Td (tetanus-diphtheria booster) and VZV (chicken pox), if they haven't already had the disease. The *Healthy People 2000* goal is to increase to 90% the proportion of children up through age 12 who are fully immunized.

This measure estimates the percentage of 13 year olds in the plan who received all of the appropriate immunizations. ***This measure is required for reporting.***

Substance Counseling for Adolescents

Adolescence is a time of dramatic physical, cognitive, social and emotional changes. Such change can lead to alcohol, tobacco and drug use, all of which can raise the risk of health problems. In the United States, 1 in 5 adolescents has smoked cigarettes and 1 in 11 has drunk alcohol by the age of 11. By the age of 15, 1 in 7 adolescents smokes on a daily basis, while 1 in 3 has drunk excessively at least once. Many experts agree that health care providers should counsel adolescents to help prevent alcohol and other drug abuse problems, identify adolescents in trouble, and offer referrals to self-help resources and treatment services. The *Healthy People 2000* goal is to reduce the proportion of young people who have used alcohol, marijuana and cocaine in the past month: by 13% for alcohol use among 12-17 year olds and by 29% among 18-20 year olds, by 3% for marijuana use among 12-17 year olds and by 8% among 18-20 year olds and by 1% for cocaine use among 12-17 year olds and by 2% among 18-20 year olds.

This measure estimates the percentage of adolescents 12 to 21 years old who were counseled on substance abuse during the reporting year. ***This measure is being evaluated for inclusion in a future reporting set.*** We need to determine the extent to which plans are recording substance abuse counseling accurately and completely, and how often substance abuse counseling is done as part of adolescent well-care visits. In addition, we need to determine at what age this counseling should begin. These issues, among others, will be evaluated during the testing phase.

ADULTS

Number of People in the Plan Who Smoke

Smoking is the leading preventable cause of death in the United States and is responsible for more than 400,000 deaths each year. One out of two lifelong smokers will die from a smoking related disease. In addition, the total economic cost of smoking (including loss of productivity) was about $100 billion in 1990, with the direct medical costs associated with smoking amounting to 7.1% of national medical expenditures.

The 1990 Surgeon General's Report concluded that quitting smoking reduces the risk of premature death. In fact, it can reduce a person's risk of dying in the next 15 years by about 50%. Measuring how many adult plan members currently smoke can be used to determine how important a problem smoking is for a plan. Furthermore, changes over time may demonstrate how successful a health plan's efforts to get people to stop smoking have been.

This measure estimates the percentage of adults in the plan who smoke. ***This measure is being evaluated for inclusion in a future reporting set.*** The impact that plans can make on prevalence may be as low as 1% per year. Thus, the use of smoking prevalence to distinguish between plans needs to be assessed. A risk-adjustment strategy may be needed to enable this measure to be used for plan comparisons. These issues, among others, will be evaluated during the testing phase.

Advising Smokers to Quit

Seventy percent of smokers are interested in stopping smoking completely and smokers report that they would be more likely to stop smoking if a doctor advised them to quit. A number of clinical trials have demonstrated the effectiveness of clinical quit-smoking programs. Getting even brief advice to quit is associated with a 30% increase in the number of people who quit.

This measure looks at the percentage of adult smokers or recent quitters who received advice to quit smoking from a health professional in the plan. ***This measure is required for reporting.***

Smokers Who Quit

Twenty-five percent of Americans (46 million adults) were smokers in 1993. Quitting smoking reduces the risk of lung and other cancers, heart attack, stroke and chronic lung disease. Women who stop smoking before pregnancy or during the first three months of pregnancy reduce their risk of having a low-birth weight baby to the same risk as women who never smoked. The excess risk of coronary artery disease is reduced by about half after one year of quitting and then continues to decline gradually. Studies have also shown that quitting smoking saves money. Smokers who quit before age 45 are likely to avoid 54% to 67% of expected lifetime economic losses due to smoking and those over age 70 are likely to avoid 32% to 52% of such costs.

This measure estimates the percentage of adult smokers in the plan who quit smoking in the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** Plans may experience success at first, with smokers who are less entrenched in the habit.

However, over time, a plan's success may diminish as it tries to influence the more hard-core smokers. Because plans will be at different stages in their efforts, a risk-adjustment strategy may be needed to make this a valid measure for comparing between plans. These issues, among others, will be evaluated during the testing phase.

Flu Shots for High-Risk Adults

People with chronic conditions, such as heart or lung disease, diabetes, immunodeficiency, Hodgkin's disease or cancer have a higher risk of suffering from complications of influenza, such as pneumonia, and dying from these complications than otherwise healthy people. Experts recommend that these individuals receive flu shots every year to prevent the flu or to reduce the risk of complications if they become infected.

This measure estimates the percentage of adult plan members who have underlying health problems that put them at risk for complications from the flu who received the influenza vaccine during the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** The need for flu shots among high-risk patients is clear; however, the definition of "high-risk" is so broad that the ability of plans to effectively change the immunization rate for the group as currently defined is questionable. To avoid encouraging the inefficient use of resources, a more actionable population definition needs to be developed. Flu shots are often given out of plan, and there is no requirement for documenting the flu shot, as there is for childhood immunizations. It may be more feasible to collect these data through survey. These issues, among others, will be evaluated during the testing phase.

SENIORS

Flu Shots for Older Adults

Influenza accounts for 10,000 to 40,000 or more deaths each year in the United States. Older adults are at high risk for developing more serious infections, such as pneumonia, following the flu. For that reason, experts recommend that all adults over age 65 receive flu shots every year to reduce the risk of developing serious complications if they become infected. Vaccination programs against influenza have been shown to reduce the incidence of illness and death, as well as to be cost effective. The *Healthy People 2000* goal is to increase to at least 80% the proportion of seniors immunized against influenza.

This measure looks at the percentage of plan members over 65 who received the influenza vaccine prior to the past year's flu season. ***This measure is required for reporting.***

Early Detection and Screening

Breast Cancer Screening

Breast cancer is the most common type of cancer among American women. Experts estimate that a woman in this country stands a one in nine (about 11%) chance of developing breast cancer at some point in her life, assuming she lives to age 85. In fact, each year in the United States, more than 175,000 women are diagnosed with breast cancer—equivalent to another woman learning she has breast cancer every three minutes. An estimated 46,000 women die of the disease every year, according to the American Cancer Society. Yet death from breast cancer can be significantly reduced by identifying and treating the cancer as early as possible.

Mammograms are the most effective method for detecting breast cancer at the time it is most treatable. A mammogram is an x-ray of the breast that can reveal tumors too small to be felt by hand and can show other changes in the breast that may suggest cancer. When high-quality equipment is used and the x-rays are read by well-trained radiologists, 85% to 90% of cancers are detectable. Breast cancer is most commonly found in women between 50 and 64 years old. The *Healthy People 2000* goal is to increase to at least 60% the proportion of women who had at least one mammogram during the past two years.

This measure estimates the percentage of the plan's female members between the ages of 52 and 69 who had at least one mammogram during the past two years. ***This measure is required for reporting.***

Stage at Which Breast Cancer Was Detected

The survival rate for breast cancer patients is only 18% when the cancer has spread to distant organs (late-stage cancer), but it is 73% when the cancer has not spread beyond the surrounding region, and 94% when the cancer is still localized.

This measure assesses the effectiveness of screening by evaluating in how many women breast cancer was detected in the later stages. ***This measure is being evaluated for inclusion in a future reporting set.*** The small number of expected breast cancer cases may make it impossible to calculate rates that are meaningful or that permit detection of differences between plans. This issue, among others, will be evaluated during the testing phase.

Cervical Cancer Screening

Approximately 13,000 new cases of cervical cancer (cancer of the opening of the uterus, or womb) are diagnosed annually. Cervical cancer can be detected in its early stages by regular screening using a Pap smear test, which has been credited with reducing the number of deaths from cervical cancer by as much as 75%. A number of organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association, and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 18 years old. The *Healthy People 2000* goal is to increase to at least 85% the proportion of women who received at least one Pap smear during the past three years.

This measure estimates the percentage of women in the plan age 21 to 64 who had at least one Pap smear during the past three years. *This measure is required for reporting.*

Chlamydia Screening

Chlamydia is not widely known, but it is an important health problem. It is the most common sexually transmitted bacterial disease in the United States, with an estimated 2 million new infections in women each year. It is usually a silent illness; about 70% of infected women have no symptoms. Left untreated, chlamydia can cause pelvic inflammatory disease, infertility, ectopic pregnancy and chronic pelvic pain. Regular screening for the infection by testing for it during annual gynecological check-ups is often the only way to detect it so it can be treated before complications arise. Detection and treatment also help keep the person from spreading the disease.

This measure estimates the percentage of women between the ages of 15 and 25 who were screened for chlamydia in the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** Since sexually active women are the group of interest for chlamydia screening, a reliable method needs to be developed to distinguish women who are sexually active from those who are not. We also need to assess how reliably chlamydia screening is reported. These issues, among others, will be evaluated during the testing phase.

Colorectal Cancer Screening

Cancer of the colon or rectum is the second leading cause of death from cancer, accounting for 14% of cancer deaths in men and 15% of deaths among women. Annually, about 150,000 new cases of colorectal cancer are diagnosed and another 56,000 individuals die from the disease. Detection of this cancer at an early stage greatly increases a person's chances for survival. Five-year survival rates are 91% for those diagnosed with localized cancer, compared to 60% for cancers that have spread throughout the region and 6% for those that have spread to distant organs.

Five screening interventions are used to detect colorectal cancer: digital rectal examination (the doctor inserts a gloved finger into the rectum to check for abnormalities), fecal occult blood testing (a lab test that checks for blood in the stool), sigmoidoscopy (a thin, flexible optical device allows the doctor to examine the last two feet of the colon), air contrast barium enemas (a chalky liquid is released into the colon and then an x-ray is taken of the colon wall), and colonoscopy (a thin, flexible optical device allows the doctor to examine the colon and remove any small protrusions or cancers). Fecal occult blood testing and sigmoidoscopy have been suggested for use in screening the general population, while barium enema and colonoscopy are recommended for use only among those at increased risk for developing the disease.

This measure estimates the percentage of plan members age 55 and older who have been screened for colorectal cancer. ***This measure is being evaluated for inclusion in a future reporting set.*** While colorectal cancer screening is important, some screening procedures are uncomfortable, and some patients may decide not to have the screening even if it is recommended. A valid way of dealing with patient compliance needs to be developed. This issue, among others, will be evaluated during the testing phase.

Maternity Care

Prenatal Care in the First Trimester

Health plans that provide timely, thorough and effective prenatal care can help reduce a woman's likelihood of delivering a low birth-weight infant and can detect and address maternal health problems early in the pregnancy. Early prenatal care is also an essential part of what is needed to help a pregnant woman prepare to become a mother. Good prenatal care plays a critical role in reducing infant mortality. Regular prenatal visits help health care providers identify and treat or prevent problems early. Problems are often easily corrected when discovered early, but left untreated they can threaten the health of both mother and child. The *Healthy People 2000* goal is to increase to 90% the proportion of women receiving prenatal care during the first trimester.

This measure estimates the percentage of pregnant women in the plan who began prenatal care during the first 13 weeks of pregnancy. ***This measure is required for reporting.***

Low Birth-Weight Babies

In the United States, 263,000 low birth-weight babies are born each year. Low birth-weight infants weigh less than 5.5 pounds, while very low birth-weight babies weigh less than 3.3 pounds. Low birth weight is associated with higher risk of both infant death and disability. While many risk factors for low birth weight fall outside the control of the health care provider, timely and comprehensive prenatal care and the careful management of women at high risk for premature delivery can lower the possibility of having an underweight baby. The *Healthy People 2000* goal is to reduce to 5% or less the proportion of babies born underweight.

This measure estimates what percentage of babies born to plan members were underweight (either low or very low birth weight). ***This measure has been deferred for the 1996 reporting year, because of persistent problems with risk adjustment and the difficulty of identifying low birth-weight infants using administrative data. Improved specifications will be developed and the measure will be required for the 1997 reporting year.***

Check-Ups After Delivery

The six weeks after giving birth are a period of physical, emotional and social changes for the mother, during a time when she is also adjusting to caring for her new baby. So that the new mother can be evaluated and receive any necessary assistance, the American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once by the 42nd day after giving birth. The first postpartum visit includes a physical examination, and also provides an opportunity for the health care provider to answer parents questions and give family planning guidance and counseling on nutrition.

This measure estimates the percentage of women who had live births who had a postpartum visit within six weeks after delivery. ***This measure is required for reporting.***

Treating Acute Illness

CHILDREN

Treating Children's Ear Infections

By their first birthday, about half of all children born in the U.S. have had at least one ear infection (otitis media) and 20% have had more than three. Ear infections account for 40% of all antibiotics prescribed to children. Prescribing the wrong antibiotic can cause serious problems. Using new, broad-spectrum antibiotics for uncomplicated infections may create resistance to those antibiotics and leave providers with no way to treat subsequent ear infections. It also creates a risk that these antibiotics won't work for other, more serious infections.

This measure looks at how often children with acute otitis media were given the appropriate treatment. ***This measure is required for reporting.***

ADULTS

Beta Blocker Treatment After a Heart Attack

About 1.5 million Americans annually experience a heart attack (or myocardial infarction) and about 500,000 of them die from it. The American Heart Association estimates that the total annual cost of medical care and lost productivity due to heart attacks is $12 billion to $24 billion. A heart attack occurs when the blood supply to part of the heart muscle is severely reduced or stopped and heart tissue is destroyed by a lack of oxygen. People who have had a heart attack are at higher risk of having another one. One medical therapy that has been shown to lower that risk is the use of beta blockers, which lower blood pressure and reduce how hard the heart has to work.

This measure estimates the number of plan members who were discharged from the hospital after a heart attack (and did not show evidence that beta blockers might have negative side effects for them) were dispensed a prescription for beta blockers. ***This measure is required for reporting.***

Aspirin Treatment After a Heart Attack

Like beta blockers, aspirin is a drug that is given to people after a heart attack to reduce their risk of having another one. Aspirin affects the way the blood clots by making platelets (a certain group of blood cells) less "sticky"; this both reduces the accumulation of platelets that can block an artery and prevents the formation of a clot when bleeding occurs. Taking aspirin after a heart attack can reduce the chances of death and stroke, in addition to reducing the chances of having another heart attack.

This measure looks at how many plan members who were discharged from the hospital after a heart attack were instructed to take aspirin. ***This measure is being evaluated for inclusion in a future reporting set.*** Aspirin is an over-the-counter drug, so no prescription is filled, which may prevent plans from getting accurate data for the measure. The small number of patients who have heart attacks may also limit the measure's power to detect differences between health plans. These issues, among others, will be evaluated during the testing phase.

Follow-Up After an Abnormal Pap Smear

In 1994, approximately 15,000 women were diagnosed with cervical cancer and 4,600 died from it. Routine Pap smears, which detect cell changes that may lead to cancer, are the preferred method for detecting this disease at an early stage. Women whose Pap smear detects a problem need additional diagnostic tests to guide appropriate intervention. At the very least, a second Pap smear should be performed to confirm the results of the first. An abnormal Pap test that is not followed up creates a real risk that there will be a needless delay in the diagnosis of cancer and that the likelihood of cure will decrease.

This measure estimates the percentage of women with abnormal Pap smears who received timely follow-up evaluation. ***This measure is being evaluated for inclusion in a future reporting set.*** A valid way of defining and measuring what constitutes an abnormal Pap smear needs to be developed. Also, since different levels of abnormalities require different kinds of follow-up, a way of determining what follow-up should be considered appropriate needs to be defined. The small number of women whose Pap smears are abnormal may limit the usefulness of this measure for detecting differences between health plans. These issues, among others, will be evaluated during the testing phase.

Follow-Up After an Abnormal Mammogram

Because survival of breast cancer is highly dependent on the stage of the cancer when it is detected, a key step in the process of treating the disease is following up with a patient whose mammogram shows a tumor or abnormal growth to determine if cancer is present, so that necessary treatment can be started as soon as possible. Timeliness of follow-up is important for preserving treatment options (such as breast-conserving surgery), diminishing the psychological stress associated with uncertainty and ensuring the best results.

This measure estimates the percentage of women with abnormal mammograms who received appropriate follow-up care within 60 days. ***This measure is being evaluated for inclusion in a future reporting set.*** A valid way of defining and measuring what constitutes an abnormal mammogram needs to be developed. Also, since different levels of abnormalities require different kinds of follow-up, a way of determining what follow-up should be considered appropriate needs to be defined. The small number of women whose mammograms are abnormal may limit the usefulness of this measure for detecting differences between health plans. These issues, among others, will be evaluated during the testing phase.

Treating Chronic Illness

Use of Appropriate Medications for People with Asthma

If asthma is not properly managed, the patient is likely to have an attack (an episode where the airways become constricted and it becomes very hard to get enough oxygen) severe enough to require hospitalization or even lead to death. Proper management of asthma includes the use of appropriate medications that act directly to reduce the inflammation of the airways. There are two medications — corticosteroids (often called steroids) and cromolyn sodium — that are the mainstays of maintenance therapy for people with moderate or severe asthma.

This measure estimates the percentage of enrollees with asthma who were dispensed at least one prescription for inhaled corticosteroids and/or cromolyn during the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** The drugs mentioned above are not medically appropriate for people with mild, intermittent asthma; therefore a valid way of distinguishing among levels of severity needs to be developed. Further, among moderate and severe asthmatics, the duration of treatment can be quite long. A single prescription is likely not adequate to assess whether effective care is being given. A valid way of measuring the entire regimen needs to be developed. The Robert Wood Johnson Chronic Care Initiative is evaluating and testing asthma measures. NCQA is collaborating in this effort to assure the best measure is developed for this important clinical area. These issues, among others, will be evaluated during the testing phase.

Eye Exams for People with Diabetes

Diabetes is the leading cause of adult blindness in the United States. Therefore, it is important that people with diabetes have their eyes examined regularly so that appropriate treatment can be initiated at the first sign of a problem. To determine if there are any problems, the eye doctor examines the retina, a light-sensitive layer of tissue in the back of the eye that receives and transmits visual information to the brain.

How often diabetics should have the eyes examined is currently a matter of some debate. Clearly, diabetics with advanced disease require examinations every year. However, diabetics with mild, or no, eye disease can be safely screened every other year.

This measure estimates the percentage of diabetic plan members who received an eye exam in the past year. Because some diabetics can be screened less frequently than annually, one would not necessarily expect a screening rate of 100% in each plan. We are working to develop a measure that will take into account the appropriate screening interval for diabetics with different needs, and will replace this measure with one that is more refined when such a measure is available. ***This measure is required for reporting.***

Monitoring Diabetes Patients

This year alone, 160,000 Americans will die from diabetes–more than from breast cancer, AIDS and other chronic diseases combined. Diabetes costs Americans more than $92 billion in health care expenditures and lost productivity annually. Diabetes is the single leading cause of kidney failure and amputations not related to accidents. However, many health problems associated with the condition can be prevented or moderated with proper care, ensuring that most diabetics can live long, healthy lives.

An important part of managing diabetes, therefore, involves making sure glucose levels are kept within acceptable limits. To evaluate whether glucose is being maintained within acceptable limits, it is important to regularly perform a blood test called a glycohemoglobin (glycosylated hemoglobin) level test.

This measure estimates the percentage of diabetic patients enrolled in the plan who received at least two blood tests to check glycohemoglobin levels during the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** The screening recommendations for insulin-dependent diabetics are different from those for non-insulin-dependent diabetics. Thus, a sound methodology for distinguishing between insulin-dependent and non-insulin-dependent diabetics is needed. It is also not clear whether the number of screenings or the actual screening results should be measured. These issues, among others, will be evaluated during the testing phase.

Prevention of Stroke in People with Atrial Fibrillation

Atrial fibrillation is a disorder found in 2.5 million Americans. It causes the two small chambers of the heart — the atria — to quiver instead of beating effectively. Because of this, blood is not pumped completely out of them when the heart beats — blood pools and may clot. If a blood clot from one of the atria becomes lodged in an artery in the brain, a stroke results. According to the American Heart Association, 15% of strokes occur in people with atrial fibrillation. Taking warfarin, a prescription blood-thinning (anticoagulant) medication, decreases by two-thirds the probability that people with this condition will have a stroke and lowers their risk of death by one-third.

Surprisingly, current evidence suggests that a very large number of people with atrial fibrillation are **not** receiving warfarin. This means that these people are at much higher risk for stroke than they need to be.

This measure estimates the percentage of plan members who have been diagnosed with chronic atrial fibrillation who received a prescription for warfarin. ***This measure is being evaluated for inclusion in a future reporting set.*** Warfarin is used at different stages in the management of atrial fibrillation. Also there are some patients who should not take warfarin at all, thus, a method for identifying which patients should be on warfarin needs to be developed. These issues, among others, will be evaluated during the testing phase.

Outpatient Care of Patients Hospitalized for Heart Failure

About 2 million Americans annually experience heart failure, a condition in which the heart keeps working but pumps ineffectively, causing a buildup of fluid in the body. Heart failure can be caused by many forms of heart disease, including coronary artery disease, past heart attack, and high blood pressure. Mortality rates from heart failure are 10% within 1 year of a cardiac problem due to heart failure and 50% within 5 years. In addition, the fatigue and the swelling of the feet and legs (called edema) caused by the condition may significantly affect a person's ability to perform everyday tasks. In 1990, $7 billion was spent on hospitalization and $10 billion was spent on overall health care for this condition.

A type of prescription drug called angiotensin-converting enzyme (ACE) inhibitors significantly reduces death rates and symptoms in patients with heart failure. ACE inhibitors cause arteries to expand, making it easier for blood to flow, thus reducing the heart's work load. Medical literature on the subject strongly suggests that most patients with heart failure should receive ACE inhibitors as part of their post-hospital discharge treatment program.

This measure estimates the percentage of plan members who were prescribed ACE inhibitors within 90 days of discharge after hospitalization for heart failure. ***This measure is being evaluated for inclusion in a future reporting set.*** A risk-adjustment strategy needs to be developed to make it a valid measure for comparing between plans. Some plans may also have difficulty collecting sufficient data for this measure. A strategy needs to be developed for dealing with cases in which ACE inhibitors are not recommended. It must also be decided whether to look at all patients with congestive heart failure or just newly diagnosed ones. These issues, among others, will be evaluated during the testing phase.

Cholesterol Management of Patients Hospitalized for Coronary Artery Disease

About 1.5 million Americans annually are diagnosed with coronary artery disease, where the arteries supplying the heart muscle with blood are narrowed, blocking blood flow. Another 490,000 Americans die from the disease each year. The annual direct and indirect health care costs from the condition are estimated to be $47 billion. One of the changeable factors that contributes to excess death among persons with heart disease is high cholesterol. Those with very high cholesterol levels have a four-fold increased risk of death. Therefore, it is important for patients who have been hospitalized for coronary artery disease to keep their cholesterol below the recommended level.

Total cholesterol levels are composed of two parts: low-density lipoprotein cholesterol (LDL-C) and high-density lipoprotein cholesterol (HDL-C). The association between cholesterol and increased risk of death from heart disease is more strongly linked to LDL-C.

This measure estimates the percentage of plan members hospitalized for coronary artery disease whose LDL-C level was below 100 mg/dL 12 months after the hospitalization. ***This measure is being evaluated for inclusion in a future reporting set.*** Whether it is better to measure cholesterol relative to a target value (100 mg/dL) or to look at changes in cholesterol level over time needs to be determined. A risk-adjustment strategy may need to be developed to account for plans that have patients with more treatment-resistant disease. These issues, among others, will be evaluated during the testing phase.

Controlling High Blood Pressure

High blood pressure, or hypertension, is one of the most common chronic diseases among American adults. About 43 million people — 30% of the adult population — have hypertension. It is considered a risk factor for heart disease because it increases the heart's work load, causing it to enlarge and weaken over time. Controlling high blood pressure is essential in preventing heart disease. For people with a personal or family history of high blood pressure, it is important to know how well a plan manages the blood pressure of members with hypertension. A doctor or nurse uses a stethoscope and a pressurized cuff to measure the pressure in an arm artery at two times: during a

heartbeat (systolic pressure) and between beats (diastolic pressure). For most adults, a blood pressure reading less than 140/90 means there is no cause for alarm.

This measure looks at the proportion of adult members with a diagnosis of hypertension whose blood pressure is adequately controlled. ***This measure is being evaluated for inclusion in a future reporting set.*** We need to determine whether to measure control of hypertension in terms of an absolute level of blood pressure or a change in blood pressure over time. This issue, among others, will be evaluated during the testing phase.

Assessment of How Breast Cancer Therapy Affects the Patient's Ability to Function

Adequate treatment of breast cancer must include attention to the clinical, psychological and functional outcomes of care. How the patient herself rates the repercussions of the treatment provides valuable information about how both the disease and treatment affect an individual's ability to function in everyday life.

This measure involves a 28-item self-administered survey designed to assess the patient's quality of life following treatment for cancer. It includes questions about the patient's physical, emotional and functional well-being, social and family situation and relationship with her doctor. ***This measure is being evaluated for inclusion in a future reporting set.*** Because the number of breast cancer cases is relatively low, this measure may not be useful for comparing health plans. The small numbers of cases may also threaten individual patient confidentiality. We need to determine how to summarize the results of the survey in a valid way. These issues, among others, will be evaluated during the testing phase.

The Health of Seniors

Maintaining the ability to function in everyday life is critically important to a person's quality of life. This measure reflects the belief that high quality health care can either improve or at least slow the rate of decline in its senior members' ability to lead an active and independent life.

Information on ability to function may help a health plan select an appropriate treatment program for a member. How well a person is functioning may also be used to predict other factors, such as whether people will need long-term care or how long they might live. For example, one study showed that persons age 70 to 79 who rated their health as poor or bad were 19 times more likely to die within three years as those who rated their health as excellent.

This measure assesses how effectively the plan is helping its elderly members maintain a high quality of life, by using a survey that asks them to rate whether their ability to function has improved or worsened over time. ***This measure is required for reporting.***

Prescription of Antibiotics for the Prevention of HIV-Related Pneumonia

Pneumocystis carinii pneumonia is the most common infection among patients with advanced HIV infection. In fact, it occurs in approximately 50%-66% of HIV-infected adults and it is the most common cause of hospitalization and death for those with HIV infection. Fortunately, giving HIV-infected patients small doses of the same antibiotics used to treat this type of pneumonia can help prevent it from developing in up to 80% of cases. The Centers for Disease Control and Prevention recommend prophylaxis (the use of antibiotics to prevent rather than treat a disease) for all HIV-infected patients with T-cell counts below 200 (which indicates severe suppression of their immune systems).

This measure estimates the percentage of HIV-infected plan members with T-cell counts below 200 who have been prescribed appropriate antibiotics. ***This measure is being evaluated for inclusion in a future reporting set.*** Although HIV has been established as a reportable infection by the CDC, there is some concern about providers' willingness to release records and other information about HIV patients. Since the number of HIV patients is expected to vary considerably from region to region, some plans may not have enough of these patients to calculate a meaningful statistic for plan-to-plan comparison. These issues, among others, will be evaluated during the testing phase.

Behavioral Health

Follow-Up After Hospitalization for Selected Mental Illnesses

According to the National Institute for Mental Health, a significant percentage of individuals experience some form of mental illness (including manic depression, paranoia and schizophrenia), yet only a small proportion of these are medically diagnosed. Suicide, the most serious risk to those with mental illness, causes 15% of the deaths associated with untreated mood disorders. Those deaths tend to occur 4 to 5 years after the first clinical episode. The *Healthy People 2000* goal is to reduce to less than 10% the prevalence of mental disorders among children and adolescents.

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner within 30 days of discharge is necessary to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

This measure estimates the percentage of plan members age 6 and over who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 30 days after their discharge. ***This measure is required for reporting.***

Screening for Chemical Dependency

Alcohol and drug abuse take an enormous toll — physical, psychological and financial — on millions of lives. According to the American Psychiatric Association, 10 million U.S. adults and 3 million children under age 18 are alcoholics. Others place the total estimate as high as 22 million. The National Academy of Science's Institute of Medicine estimates that more than 5.5 million Americans use drugs to the extent of suffering physical and psychological distress if they stop. Unfortunately, chemical dependency is a condition that frequently goes undetected for long periods. Diagnosis is necessary to help the affected person get appropriate treatment.

This measure estimates whether a plan is trying to identify members with chemical dependency problems by educating their health care providers. It does this by asking plan members if their doctor has asked them about alcohol or drug abuse during the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** More needs to be known about how well respondents' answers reflect whether they were actually screened for substance abuse problems. Also, we need to establish whether routine screening actually results in treatment for substance abuse. These issues, among others, will be evaluated during the testing phase.

Continuity of Care for Substance Abuse Patients

Recovery from substance dependence and abuse does not follow a straight, even course. Relapses are extremely common, especially during early recovery, when the stress may be hardest to handle. In substance abuse rehabilitation, individuals often must change their approaches to handling stress, relationships and habits that contribute to the substance abuse. The best way to help patients "stay on the wagon" after detoxification is to provide appropriate follow-up care.

That is why it is important to examine the effectiveness of the plan's system for providing continuity of care to members with substance abuse problems. This measure looks at the number of patients discharged from a detoxification program to determine how many received follow-up care and how many were readmitted. ***This measure is being evaluated for inclusion in a future reporting set.*** The categories of follow-up encounters that are reported for patients discharged from the hospital after substance abuse detoxification need to be further defined with regard to the appropriateness of the care given and whether they may signify continuous care or a relapse. The applicability of this measure, which was originally designed for use by behavioral health care organizations, to all health plans needs to be evaluated. These issues, among others, will be evaluated during the testing phase.

Failure of Substance Abuse Treatment

When a patient who has undergone detoxification treatment for chemical dependency requires the same treatment again within a short period of time, this signifies that the treatment of this patient's substance abuse problem may not have been successful. Patients may require repeated detoxification for a number of reasons, such as severity of the illness that makes it difficult for the patient to respond to treatment, or problems in the provision of effective treatment by the health plan, and other factors.

This measure estimates the percentage of people who required repeated treatment. ***This measure is being evaluated for inclusion in a future reporting set.*** A risk-adjustment strategy addressing the characteristics of the substance abuse problem and sociodemographic factors of the enrolled population needs to be developed to assure that the measure is valid for comparing plans. The applicability of this measure, which was originally designed for use by behavioral health care organizations, to all health plans needs to be evaluated. These issues, among others, will be evaluated during the testing phase.

Continuation of Depression Treatment

Major depression and recurrent depression (dysthymia) are among the most prevalent mental disorders, affecting about 10% of all adults each year. According to the Agency for Health Care Policy Research's *Guideline on Depression in Primary Care*, clinical depression may include apathy, anxiety or irritability, rather than or in addition to sadness. These problems may continue for months and severely impact a person's functioning in everyday life.

Fortunately, about 65%-70% of people with major depression respond to antidepressant medication. The treatment of clinical depression includes several phases. After the treatment of the acute phase of the depression, a therapy program must be set up to prevent relapses. Patients who initially received antidepressants should continue to take these medications until they and their physicians agree it is safe to decrease or discontinue them. Premature discontinuation of treatment is associated with a 25%

relapse rate within two months. The World Health Organization recommends indefinite maintenance therapy for patients who have experienced two episodes of depression within a 5-year period.

This measure looks at the percentage of people with major depression who are taking antidepressants and who were prescribed at least four months of antidepressants. ***This measure is being evaluated for inclusion in a future reporting set.*** We need to know more about the influence of patient compliance on the rates reported in this measure. A method is needed to identify patients who received a prescription for a new episode of depression, so that patients in a later phase of therapy who appropriately discontinued their medication can be excluded from the measure. The method of data collection is likely to have an influence on the rates reported in this measure and affect comparability of data. These issues, among others, will be evaluated during the testing phase.

Availability of Medication Management and Psychotherapy for Patients with Schizophrenia

Schizophrenia, one of the most debilitating mental disorders, affects about 1% of American adults. It is characterized by a changed sense of reality, probably caused by certain changes in the brain chemistry. This condition affects every aspect of psychological functioning, including all the ways in which people think, feel, view themselves and relate to others.

Schizophrenic patients are usually treated with powerful drugs called antipsychotics or neuroleptics, which can reduce confusion, anxiety, delusions and hallucinations. According to the National Mental Health Advisory Council and the American Psychiatric Association, more than 60% of those with schizophrenia can be relieved of acute symptoms with proper therapy. As schizophrenia often runs its course over many years, patients may need to take medications for long periods. However, like other medications, psychiatric drugs have side effects and must be used with care. Ideally, psychiatrists should monitor their patients to be sure they continue to do well on their medication. This is important to regulate the appropriate doses and types of medications, monitor undesirable medication effects and coordinate care with family members, social agencies and other physicians and/or mental health practitioners involved in the care of the patient.

The purpose of this measure is to assess whether a plan adequately manages the drug treatment of this group of mentally ill members. To do this, it determines the number of adult members with schizophrenia who had a least four medication-management visits or psychotherapy visits with a psychiatrist in the past year. ***This measure is being evaluated for inclusion in a future reporting set.*** This measure's ability to predict improved outcomes is not known. We need to know more about the influence of patient compliance on the rates reported in this measure. The applicability of this measure, which was originally designed for use by behavioral health care organizations, to all health plans needs to be evaluated. The low prevalence of schizophrenia may make it difficult for smaller plans to obtain meaningful data. These issues, among others, will be evaluated during the testing phase.

Appropriate Use of Psychotherapeutic Medications

Prescribing psychotherapeutic drugs to patients who do not really need them is of particular concern, because many of these drugs have serious side effects and may affect the person's normal functioning.

This measure tries to assess to what extent the plan uses these drugs appropriately by determining what percentage of enrollees given psychotherapeutic drugs were diagnosed with a condition that warrants such a prescription (including senile or presenile psychosis, alcoholic psychosis, drug psychosis, transient organic psychosis, chronic psychosis, schizophrenic psychosis, affective psychosis, paranoid states or other non-organic psychoses). ***This measure is being evaluated for inclusion in a future reporting set.*** This measure depends heavily on health plans' ability to link diagnostic and pharmaceutical data, and more needs to be known about how this influences rates reported for the measure. This issue, among others, will be evaluated during the testing phase.

Family Visits for Children Undergoing Mental Health Treatment

An important factor in the treatment of patients with behavioral health disorders is understanding the importance of their home environment as it contributes to stress or serves as support for the patient. This is especially true of children, where involving family/caregivers in the treatment process may be vital to its success.

This measure assesses to what extent the health plan tries to involve family/caregivers in the treatment of children age 12 and under by counting the number of them who had at least one family visit during the calendar year. ***This measure is being evaluated for inclusion in a future reporting set.*** More needs to be known about how to identify children who received family services, as these may not be coded as behavioral health services. It may also be difficult to identify children receiving treatment for behavioral health problems, as practitioners may be hesitant to document a mental health diagnosis for a child in order to avoid stigmatization. The applicability of this measure, which was originally designed for use by behavioral health care organizations, to all health plans needs to be evaluated. These issues, among others, will be evaluated during the testing phase.

Patient Satisfaction with Mental Health Care

For many consumers, an important factor in making a health care decision is how satisfied people similar to themselves were with the health care they received. This measure provides information on how adults rated three aspects of the mental health care provided by their plan. These include their overall satisfaction with the care received, whether the care they received helped them, and whether they were able to get an appointment in a timely fashion. When making comparisons across plans based on these ratings, consumers should keep in mind that many factors can influence patients' answers. While mental health professionals can positively influence their patients in helping them understand what treatment goals are realistic for them, factors such as patients' familiarity with managed care, and the severity and potential for improvement of their conditions can also influence patients' answers.

This measure is being evaluated for inclusion in a future reporting set. A risk-adjustment strategy addressing patients' diagnoses and sociodemographic factors may need to be developed to make this measure useful for comparing plans. Confidentiality may be of some concern because of the sensitive nature of the diagnoses, and patient permission may be required if the survey is being administered by an independent group. The applicability of this measure, which was originally designed for use by behavioral health care organizations, to all health plans needs to be evaluated. These issues, among others, will be evaluated during the testing phase.

USE OF SERVICES

This domain provides information on how a plan manages and expends its resources, which may give consumers and purchasers a sense of the plan's priorities. Consumers and purchasers should be aware, however, that use of services is affected by many member characteristics that can vary greatly among health plans, including age and sex, current medical condition, socioeconomic status and race. To make the best use of this information, consumers and purchasers should use it as a starting point for discussions with the health plan.

There are two different kinds of measures in this domain:

- "Traditional" Use of Services measures, which are often expressed as rates of service use per 1,000 member years (a number which is usually close to the number of members enrolled in a year) or member months (which can be thought of as the number of members enrolled in a year multiplied by 12) and
- Use of Services measures that express the percentage of members who received certain services. These measures are similar to the measures in the Effectiveness of Care domain in that they report information on members who were continuously enrolled in the health plan for a certain period of time.

Frequency of Ongoing Prenatal Care

Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. The frequency and adequacy of ongoing prenatal visits, therefore, is an important factor in minimizing pregnancy problems. The American College of Obstetricians and Gynecologists recommends that prenatal care begin as early in the first trimester of pregnancy as possible, with additional visits every 4 weeks for the first 28 weeks of pregnancy, every 2 to 3 weeks for the next 8 weeks, and then weekly until delivery.

This measure tracks plan members who had live births during the past year to determine the percentage of recommended prenatal visits they had. ***This measure is required for reporting.***

Well-Child Visits in the First 15 Months of Life

Well-child visits, or regular check-ups, are one of the best ways to detect physical, developmental, behavioral and emotional problems so appropriate treatment can be given. They also provide an opportunity for the physician to offer guidance and counseling to the parents. These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) recommends 6 well-child visits in the first year of life: the first within the first month of life and then around 2, 4, 6, 9 and 12 months. The *Healthy People 2000* goal is to increase to at least 90% the proportion of all babies 18 months old and younger who receive the recommended primary care services.

This measure estimates the percentage of children who had one, two, three, four, five or six well-child visits by the time they turned 15 months of age. ***This measure is required for reporting.***

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Well-child visits during the pre- and early-school years are particularly important to help children reach their full potential and become productive and successful members of society. By detecting vision, speech and language problems early, a child can be helped to improve communication skills and avoid or reduce language and learning problems. The AAP recommends annual well-child visits for 2 to 6 year olds.

This measure assesses the percentage of children who are 3, 4, 5 and 6 years of age who received at least one well-child visit with a primary care physician during the past year. ***This measure is required for reporting.***

Adolescent Well-Care Visit

An annual preventive health care visit that addresses the physical, emotional and social aspects of health and promotes a healthy lifestyle as well as disease prevention is extremely important for adolescents. Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Unintentional injuries, homicide and suicide are the leading causes of adolescent death, while sexually transmitted diseases, substance abuse, pregnancy, and antisocial behavior are important causes of physical, emotional and social adolescent problems. The American Medical Association *Guidelines for Adolescent Preventive Services*, the federal government's Bright Futures program and the new AAP guidelines all recommend comprehensive annual check-ups for adolescents.

This measure reports the percentage of plan members age 12 to 21 who had one or more well-care visit with a primary care provider during the past year. ***This measure is required for reporting.***

Frequency of Selected Procedures

This measure lists several, mostly surgical, procedures that are frequently performed and that contribute substantially to expenses. Considerable variation has been observed in how often these procedures are performed. These rates are likely to be strongly influenced by the way a health plan manages care. ***This measure is required for reporting.***

Inpatient Utilization — General Hospital/Acute Care

Inpatient utilization estimates the extent to which health plan members received inpatient hospital treatment, either because of pregnancy and childbirth, for surgery or for non-surgical medical treatment. Plans report how many hospital stays occurred during the reporting year, how long patients stayed in the hospital on average and other data. ***This measure is required for reporting.***

Ambulatory Care

This measure estimates members' use of four different kinds of ambulatory services: outpatient visits, emergency room visits, ambulatory surgery and observation room stays. Outpatient visits include office visits or routine visits to hospital outpatient departments. A health plan that effectively manages ambulatory treatment of patients should be able to keep the number of emergency room visits low. Looking at inpatient surgery (see the previous measure) and ambulatory surgery together can help purchasers

and members assess how much of the surgery done in the plan is performed on an outpatient basis. Observation rooms are usually part of hospitals' outpatient departments, where patients may stay for one or two days "for observation," during which time the physician decides whether an inpatient admission is necessary. ***This measure is required for reporting.***

Inpatient Utilization — Nonacute Care

This measure describes the extent to which members received inpatient treatment in nursing homes or rehabilitation centers. Plans report the number of stays in institutions for nonacute care in the reporting year and how long patients stayed in these institutions on average. ***This measure is required for reporting.***

Discharge and Average Length of Stay — Maternity Care

Childbirth is a very common reason for hospitalization. This measure describes how many women enrolled in the health plan gave birth during the reporting year and how long the women remained in the hospital on average after vaginal births or Cesarean section deliveries. ***This measure is required for reporting.***

Cesarean Section and Vaginal Birth After Cesarean (VBAC-Rate)

Cesarean sections are among the most frequently performed surgical procedures, and there has been concern that they are not always necessary to perform. For this reason, many women may want to know the Cesarean-section rate of a hospital or a health plan when deciding which one to choose. Women may also be interested in knowing the VBAC-rate, which tells how many women delivered vaginally after a previous Cesarean section, instead of having another Cesarean section. ***Health plans are required to report the C-Section Rate. Reporting the VBAC-Rate is not required for the 1996 reporting year. The measure VBAC-Rate has been deferred because of persistent problems with the identification of numerator and denominator for this rate from administrative sources. Health plans should develop a method to track VBAC's and repeated C-Sections, e.g., utilizing the newly introduced CPT-4 codes 59610-59622. This measure will be required for the 1997 reporting year.***

Births and Average Length of Stay, Newborns

This measure estimates how many infants were born in the health plan during the reporting year and how long these newborns remained hospitalized on average. Average length of hospital stay is listed for well newborns and for those who had medical problems. ***This measure is required for reporting.***

Mental Health Utilization — Inpatient Discharges and Average Length of Stay

Purchasers may be interested in rates of use of mental health services by members. This measure estimates how many hospitalizations for mental health disorders occurred during the reporting year and how long patients stayed in the hospital on average. ***This measure is required for reporting.***

Mental Health Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services

Several "intensity levels" of mental health care are identified: hospital treatment, day/night care (a level of intermediate care where a patient may live at home and visit a therapeutic institution during the day) and ambulatory treatment. Purchasers may want to know the percentage of members who received mental health services in each of these intensity levels. ***This measure is required for reporting.***

Readmission for Selected Mental Health Disorders

This measure estimates how many patients who got hospital treatment for mental health disorders (such as schizophrenia or depression) needed intensive treatment again, based on readmission to inpatient treatment within 3 months and a year after the first hospitalization. Patients may require readmissions for a number of reasons such as severity of illness that makes it difficult for patients to respond to effective treatment, or problems in the provision of effective treatment by the health plan, and other factors. ***This measure is required for reporting.***

Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay

Chemical dependency, most commonly alcohol dependency, is very costly to purchasers. Purchasers may be interested to know rates of use of chemical dependency services by health plan members.

This measure estimates how many hospitalizations for chemical dependency occurred during the reporting year and how long patients stayed in hospital on average. ***This measure is required for reporting.***

Chemical Dependency Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services

Several "intensity levels" of care for chemical dependency are listed: hospital treatment, day/night care and ambulatory treatment. Purchasers may want to know the breakdown of members who received mental health services in these intensity levels. ***This measure is required for reporting.***

Readmission for Chemical Dependency

This measure estimates how many patients who needed hospital treatment for chemical dependency problems had to be readmitted to inpatient treatment within 3 months and within a year after the first hospitalization. Patients may require readmissions for a number of reasons, such as severity of illness that makes it difficult for patients to respond to effective treatment, problems in the provision of effective treatment by the health plan, and other factors. ***This measure is required for reporting.***

Use of Behavioral Health Services

Access to necessary care is of particular interest to managed care consumers. Many want to know whether a plan that offers mental health coverage in any way restricts access to those services. This measure provides information about the percentage of plan members with this type of coverage who received mental health services — either a face- to-face visit or a hospital stay — during the year. This information is reported separately for patients in different age groups and with different diagnoses. Since the use of services varies depending on factors such as the age of the patient and the diagnosis, these contingencies have to be considered by the consumer when using this data for plan comparisons.

This measure is being evaluated for inclusion in a future reporting set. Plans' variable benefit structures may need to be accounted for to make this a valid measure for comparing plans. The applicability of this measure, which was originally designed for use by behavioral health care organizations, to all health plans needs to be evaluated. These issues, among others, will be evaluated during the testing phase.

Outpatient Drug Utilization

Purchasers may be interested in information on the use of prescription drugs by members and the associated costs, such as the total costs for prescribed drugs, the average cost for drugs per member and the average number of prescriptions per member within a year.

This measure provides this information for members with a pharmacy benefit. Users should keep in mind that use of pharmaceuticals is influenced by many factors, and that prescription costs may differ from plan to plan for a number of reasons, such as proportion of health plan members with a chronic condition. ***This measure is required for reporting.***

INFORMED HEALTH CARE CHOICES

People need to take an active role in their health care planning; to do so, they need to have the information and understanding necessary to make informed choices about treatment options. The measures in this domain look at how well plans are helping their members to participate in decisions about their own health care.

This domain includes three measures. One asks the plan to describe its efforts to ensure that new members know how the plan works and what alternatives, resources and grievance procedures are available to them. Another measure determines whether the plan makes its informational and educational materials available in different languages for non-English speaking members. The final measure in this domain gauges the extent to which the plan is counseling menopausal women on the risks and benefits of hormone replacement therapy.

New Member Orientation/Education

Plans should inform members about how the plan works. Consumers may want to know how a plan initiates its members into the network, and what resources it makes available to help new patients make the most of plan services.

This measure allows a plan to describe the procedures it uses to orient and educate new members on how to use its services. ***This measure is required for reporting.***

Language Translation Services

In some communities, language barriers undermine the level of care that some patients in the plan receive, and members and purchasers may be interested in the extent to which a plan provides written materials in languages other than English.

This measure asks for an inventory of all non-English language member materials. ***This measure is required for reporting.***

CHAPTER 4

Interpretation and Use

of the HEDIS Measures

INTERPRETATION OF HEDIS DATA

HEDIS 3.0 is a tool that will provide individuals with more information to help them assess the relative performance of health plans. In this section, readers are offered some guidance on how these measures can help them to assess the relative value of their health plan choices.

Different people will, and should, look at HEDIS information differently. Some are interested in getting a picture of how well a health plan performs overall. A young couple starting a family may be most interested in how well a health plan does in providing maternal and child health services. Someone with asthma might be interested in how well the health plan takes care of asthmatics. How individuals use HEDIS will depend on what they want to know. Even so, there are certain things all users should think about when they begin to use this data to make comparisons among plans.

First, no single statistic should be interpreted in isolation of others. HEDIS is a set of measures, and many of the measures are best understood in the context of others. The user should look for patterns in the data — these patterns will reveal the picture more clearly. What sort of patterns are more important? We suggest that users try to group measures that are related in some way, and look for health plans that are consistently better than (or worse than) a comparison group. Here are some of the ways that measures might be grouped to identify important patterns of performance:

- **By "domain":** Clearly, we believe there are common issues that underlie the measures in the various HEDIS 3.0 domains (Effectiveness of Care, Access/Availability of Care, Satisfaction with Care, Cost of Care, and so on). Health plans that perform consistently within one domain may be demonstrating that they have solved (or failed to solve) some of the basic problems that we are concerned about. For example, a plan that has consistently high scores on Effectiveness of Care measures may have chosen its network of providers extraordinarily well and may be providing them — across the board — with the tools (guidelines, feedback, information systems support) that they need to achieve superior outcomes. On the other hand, a plan that scores poorly on a number of Access/Availability measures may have a network that is too small or may have care management programs that are unduly restrictive and that create inappropriate barriers to access. A consistent pattern of performance within a domain should tell the user something important about how well a health plan is achieving the results that define the need for that category of measurement. That pattern is far more meaningful than isolated performance excellence or deficit.

- By "type of care" (underlying health care process): Health care is an exceedingly complex process, but it is possible to think of it as having some fundamental components (or "subprocesses"). The CPM identified several, to help organize its approach to measurement. Grouping measures along the following lines will help us understand whether the health plan effectively manages these components of care:

Disease Prevention	How effectively is the health plan preventing illness?
Screening and Early Detection	How effectively is the health plan detecting illness at the stage at which it is most treatable?
Acute and Chronic Care	How effectively is the health plan returning those who are acutely and chronically ill to their baseline level of health?
	How effectively is it preventing the loss of health and function in persons with chronic illness?

  For example, a health plan with consistently high rates of mammography, immunization, Pap testing, flu vaccination for the senior population and retinal exam screening for diabetics is very likely to be actively working to prevent disease and to detect it early. That success probably means that the health plan is educating its members about the importance of this care, is reaching out to members to alert them when routine care is required, is working to lower barriers to access for that care, is providing incentives to its providers to deliver necessary care, and is tracking members so that it recognizes when a member has (or has not) received the care needed. A conclusion about the success of the plan at achieving results by type of care is far more important than a conclusion about any single measure. And the confidence we can have that this more important conclusion is justified is much higher if we observe a pattern across measures, rather than success on an isolated measure.

- By population: The care needs of different populations vary, and health plan systems for managing care may be quite population-specific. The most obvious example, of course, is the network of providers: it may be pediatricians who care for children and internists who care for adults — but among adults it may be obstetrician/gynecologists who provide much of the care to women, and geriatricians who provide much of the care to seniors. As a result, looking at the set of measures that relate to children's health, or to women's health, or to senior's health may tell us something important about a health plan's overall ability to meet the needs of one population or another.

- By clinical condition: Similarly, the care needs of persons with different medical conditions will vary, and health plan systems for managing care may be quite condition-specific. To get a clearer sense of how effectively a plan is managing care for patients with specific conditions (heart disease, breast cancer, diabetes, and so on), look for a pattern across measures to evaluate different aspects of care for those conditions. A pattern of excellence here might suggest that a health plan has coherent and integrated strategies for managing care for those conditions, and that it has implemented those strategies successfully.

Second, there are many reasons why measured results might differ. Of course, in many cases, results will differ because one plan is doing something — providing higher quality care — that others are not. What, for example, might a health plan be doing to account for higher rates of immunization of children? Perhaps it stays open during hours (such as evenings or weekends) that are more convenient for working parents to bring in their children. Perhaps it has a computer system for tracking immunizations, so that it can determine who has missed a shot and notify those in need. Perhaps it has educated its pediatricians and family physicians about when it is appropriate to immunize a child. (Many physicians, for instance, still do not recognize that a cold or low-grade fever is no reason to delay giving a necessary vaccination.) Perhaps the plan has offered parents an incentive to bring in a child for needed shots: a chance to win a gift, a coupon for diapers, or a birthday reward when the basic immunization series is completed at age two.

These are all steps that a plan can take — and some have taken — to improve childhood immunization rates. There are other strategies, as well, that innovative health plans committed to high-quality care are using. The power of HEDIS is that it enables users to recognize those plans that have made successful efforts to improve care.

But are there other reasons that HEDIS measures may vary across plans, reasons other than differences in quality? Unfortunately, the answer is yes. While HEDIS 3.0 represents a big step forward, performance measurement is still a young and relatively immature science. There is a need for the science of measurement to improve before HEDIS data will be free of potential confounders. In the meantime, it's important that those who use HEDIS data have some sense of what other factors need to be considered when interpreting HEDIS results.

What other factors could cause HEDIS measures to vary, aside from quality of care? Here are four possible answers:

- We live in a world of chance; there is some possibility that a health plan's reported HEDIS results are different from a "true value" simply because there is some randomness in the world. This is particularly a problem because HEDIS data is often estimated from samples of health plan data. Sampling itself introduces chance into measurement — there is always some chance that the sample chosen does not truly reflect the underlying population from which it was drawn. The larger the sample, the less likely this is — but even with the relatively large samples required for HEDIS calculations, we cannot be sure that the estimated value is in fact correct. For most statistics, samples are required so that we can be quite confident that the true value is within 5-10% of the estimate. But plans that differ by less than 10% may not be truly different; that is, we may be observing differences that are due to chance (not differences in quality).
- The characteristics of the population — as well as the performance of the health plan — can affect outcomes. For example, suppose one health plan serves a group of women that is at higher risk for having low birth-weight babies because many of the women are older than 35. If this plan is compared to another plan with a younger female population, one would expect a difference in the percentage of babies that are low birth weight, even if both plans were delivering care identically. There are, in fact, many things (such as the composition of the health plan's population with respect to age, sex, race, and standard of living) that may affect health plan results, over which the plan has little or no control.

It is possible, with the right data and the right formulas, to adjust HEDIS measures so that two plans are truly comparable to each other. This is called risk adjustment, because it adjusts the rates for factors that increase the risk of bad outcomes. Getting the right data and formulas for risk adjustment takes time and effort. One of the HEDIS 3.0 measures — The Health of Seniors — includes a specific risk adjustment protocol. In general, though, techniques for risk adjusting are still needed. NCQA will be working with researchers and with health plans to develop such techniques for many of the measures that are most likely to be affected by population risk. These measures will not be reported until those techniques have been developed. Even so, virtually any statistic can be affected by differences in health plan populations if those differences are large enough; it is worth considering how population risk might affect any measured result.

- There is variation in the type, quality, and completeness of the data plans use to estimate HEDIS measures. This variation (what goes into the calculation) can cause variation in results (what comes out of the calculation). Some health plans rely on automated data (from submitted claims or transaction records, or from laboratory or pharmacy systems); others rely more heavily on the paper medical record. Neither data set is perfect; more than that, there are differences in the nature of the imperfections that might cause measures that are calculated differently to vary. Administrative datasets, for example, may underestimate rates at which services that are not reimbursed on a per-service basis are provided: estimates of immunization and screening test rates from administrative datasets may be low if those services are covered under capitated (per member, not per service) contracts; and estimates of prenatal care visit rates may be low if prenatal care visits are paid for as part of a global fee for delivery (and not specifically identified in transaction records). On the other hand, administrative records of birth weight may be inaccurate; as a result, rates calculated from hospital discharge data may underestimate the rate of low birth weight. When comparing plans, it is important to know something about the type and quality of the data used by the plans. If plans vary significantly in these regards, then there might need to be vast performance differences in order to conclude that we are really observing differences in quality of care.

- There can be errors in the calculations. Each measure in HEDIS 3.0 has clearly defined instructions for how it is to be calculated. Nevertheless, the instructions are complicated, and programmers, medical record reviewers and quality managers can and do make mistakes.

There is no protection against such errors, except to have HEDIS production systems audited by an independent third party. Some health plans have already begun to undergo such audits, to offer assurance to the users of their data that it is free of such error. NCQA believes strongly that such audits are required and is working to standardize the approach to HEDIS audits. We anticipate that the quality of HEDIS data will improve rapidly, as audits become a routine component of HEDIS reporting. NCQA hopes to make significant progress in 1996 and 1997, in order to make that possible in 1998.

USE OF HEDIS DATA

How HEDIS data will be used will depend upon the user and the user's objective. There are a number of users and uses for which HEDIS was designed.

First, purchasers — both private and public — will use HEDIS data to make comparisons among health plans. These comparisons should be informed by the issues above but, where significant and important differences between plans exist, these comparisons should help to direct health plan selection and help to support contracting and performance target-setting initiatives that currently depend only on price. HEDIS data should also stimulate a dialogue between purchasers and their health plan suppliers — a dialogue about performance, about the reasons that performance may vary from desired levels, about efforts underway at the plan to improve performance, and about other evidence that the plan may have to demonstrate that those efforts have been (or promise to be) successful.

Second, health plans will use HEDIS data to identify opportunities for improvement and to monitor the success of their efforts to improve. HEDIS data provides not only a means to track improvement internally; as a set of measurement standards, HEDIS gives health plans the ability to compare their results with other plans. This will help a given plan understand the gap between the plan's performance and the best achievable, and will help plan management set realistic targets for improvement over time.

Third, regulators — state and federal — may use HEDIS data as part of their oversight processes. Strategies for doing so are still being defined, but the potential for regulators to use available performance information to eliminate burdensome regulations seems clear. NCQA is working with a number of states to incorporate HEDIS and performance measurement into oversight processes that are streamlined and cost-effective.

Finally, we anticipate that consumers will use HEDIS data to assist them when they make choices about health plans. Some of this information may come to them directly; some of it may come from another source (their employer, or publications such as *Health Pages* and *Washington Consumers' Checkbook*, or mainstream magazines and newspapers). Some information may come to them as raw data; it is very likely that others will try to summarize raw HEDIS data to make it easier for consumers to understand.

All of these uses are appropriate, yet all of them should consider the need for thoughtful interpretation. And all of them should be made drawing on the fullest set of data available. It is important to remember that HEDIS exists as one component of a larger system for providing information about the quality and performance of health plans. As valuable as HEDIS data is in general — and as HEDIS 3.0 data will be in particular — NCQA Accreditation results provide an important complementary view. We strongly encourage users of HEDIS data — whether they be purchasers, public sector program managers, other regulators, or consumers — to use both data sets to help guide their choices among health plans. This data is readily and inexpensively available — from public sources, from health plans, or through NCQA's *Quality Compass* Reports, and should be used together to provide the most complete view possible.

HEDIS® 3.0

HEALTH PLAN EMPLOYER DATA & INFORMATION SET

TECHNICAL SPECIFICATIONS

VOLUME 2

NCQA

National Committee for Quality Assurance

EFFECTIVENESS OF CARE

CHILDHOOD IMMUNIZATION STATUS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *Medicaid HEDIS continuous enrollment standard of 12 months has been adopted.*
- *Individual vaccination rates are now required, in addition to an overall combined rate. (Individual vaccination rates were included in Medicaid HEDIS and only recommended in HEDIS 2.5.)*
- *Two hepatitis B vaccines are required. (Medicaid HEDIS required three hepatitis B vaccines.)*
- *DTaP is now approved for the first, second and third vaccines as well as the 4th vaccine.*
- *Specifications for acceptable documentation of immunizations for hybrid methodology have been modified.*
- *An exclusionary rule has been added for children who are identified as being immunocompromised, for whom the specified immunizations are contraindicated.*

Description

The percentage of Medicaid and commercially enrolled children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had no more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the following immunizations:

- Four DTP or DTaP vaccinations (or an initial DTP or DTaP followed by at least three DTP, DTaP and/or DT) by the second birthday
- Three polio (IPV or OPV) vaccinations by the second birthday
- One MMR between the first and second birthdays
- At least one H influenza type b vaccination between the first and second birthdays
- Two hepatitis B vaccinations by the second birthday (with one of them falling between the sixth month and second birthday)
- A combined rate including children who have received <u>all</u> of the immunizations listed above

Administrative Data Specification

Calculation: This specification uses membership data to identify children who have turned two years old during the reporting year and claims/encounter data to identify those two-year-old members who have received the specified vaccinations. Health plans will report six rates for each payer (i.e., Medicaid and commercial). Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two populations, are derived using all enrolled children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled for the 12 months immediately preceding their second birthday

and who were not contraindicated for any of the specified antigens. Members who have had no more than one break in enrollment of up to 45 days during the 12 months preceding their second birthday should be included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who received the following immunizations. Calculate six numerators:

- At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP or DTaP followed by at least three DTP, DTaP and/or DT (CPT-4 code 90702)
- At least three polio vaccinations-OPV or IPV-(CPT-4 code 90711 or 90712 or 90713) with different dates of service by the child's second birthday
- At least one MMR (CPT-4 codes 90705 or 90707 or 90708 or 90710 for measles and 90704 or 90707 or 90709 or 90710 for mumps and 90706 or 90707 or 90708 or 90709 or 90710 for rubella) with a date of service falling between the child's first and second birthdays
- At least one H influenza type b (CPT-4 code 90737 or 90720 or 90721) with a date of service falling between the child's first and second birthdays
- Two hepatitis B (CPT-4 code 90731 or 90744 or 90747) with different dates of service by the child's second birthday (with one of them falling between the child's sixth month and second birthday)
- A combined rate including children who have received all of the immunizations listed above.

Hybrid Method Specification

Calculation: This specification uses membership data to identify those children who have turned two years old during the reporting year and claims/encounter data and/or medical record review to identify those children who have received the specified vaccinations. Health plans will report six rates for each payer (i.e., Medicaid and commercial). Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the health plan's eligible populations. Eligible members include all children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday, who were continuously enrolled for the 12 months immediately preceding their second birthday and who were not contraindicated for any of the specified antigens. Members who have had no more than one break in enrollment of up to 45 days during the 12 months preceding their second birthday should be included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who received the following immunizations. Calculate six numerators described below, as documented through either administrative data or medical record review:

- At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial

DTP or DTaP followed by at least three DTP, DTaP and/or DT (CPT-4 code 90702)

- At least three polio vaccinations-OPV or IPV-(CPT-4 code 90711 or 90712 or 90713) with different dates of service by the child's second birthday
- At least one MMR (CPT-4 codes 90705 or 90707 or 90708 or 90710 for measles and 90704 or 90707 or 90709 or 90710 for mumps and 90706 or 90707 or 90708 or 90709 or 90710 for rubella) with a date of service falling between the child's first and second birthdays
- At least one H influenza type b (CPT-4 code 90737 or 90720 or 90721) with a date of service falling between the child's first and second birthdays
- Two hepatitis B (CPT-4 code 90731 or 90744 or 90747) with different dates of service by the child's second birthday (with one of them falling between the child's sixth month and second birthday)
- A combined rate including children who have received <u>all</u> of the immunizations listed above.

Note: For immunization information obtained from patient history, plans may count the immunization in HEDIS reports if the medical record contains the following information: an author-identified and dated immunization history or an author-identified note indicating the place of service, the name(s) of the specific antigen and the date the immunization(s) was given. Entries made in the medical record at the time immunization(s) was given must include either an author-identified note indicating the name(s) of the specific antigen and the date the immunization(s) was given, <u>or</u> the vaccine lot number. A certificate of immunization prepared by an authorized health care provider <u>or</u> agency must include the specific dates and types of immunizations administered. (Refer to the note below on transferred records.) All medical record entries must be dated by the child's second birthday (i.e., entries made retroactively may not be counted). The following do not constitute sufficient evidence of immunization for HEDIS reporting:

- *A note that the "member is up-to-date" with all immunizations, without a listing of the dates all immunizations were given and the names of the immunization agents.*
- *Records transferred from a previous health care provider or agency without a note that the authorized health care provider, to whom the records were transferred, has reviewed them.*

Notes

- In states in which the law allows for an exception to children receiving pertussis vaccination, plans may use any combination of four DTP, DTaP and/or DT.
- The 1996 Recommended Childhood Immunization Schedule includes a newly recommended Varicella-Zoster Virus Immunization. The schedule recommends that one dose of the varicella vaccine be administered at 12 to 18 months of age. <u>**To reflect the updated Childhood Immunization Schedule, HEDIS will include the varicella vaccine for the 1997 reporting year as a separate rate and not part of the combined rate.**</u>
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

- The Centers for Disease Control and Prevention, American Association of Family Physicians and American Academy of Pediatrics recommend that a total of three hepatitis B vaccinations be administered to children before 18 months of age. The first hepatitis B vaccine tends to be administered by hospitals at birth, yet may not be recorded on claims forms. Consequently, information on the first hepatitis B vaccine may not be available in health plan administrative databases. To provide health plans with transition time to develop systems that can track the first hepatitis B immunization, HEDIS specifies that only two vaccinations be provided by the child's second birthday, for reporting years 1996 and 1997. The recommended three hepatitis B vaccines will be required for the 1998 reporting year.
- Children who are identified as being immunocompromised for a specific vaccine may be excluded from the denominator of that specific vaccine rate. If a plan excludes an immunocompromised child from a specific vaccine, then the plan must exclude that child from all other specific vaccine rates, as well as from the overall rate. Thus, the denominator for each specific vaccine, and for the overall rate, will be the same. Plans that choose to exclude immunocompromised children from the measure should look for contraindications as far back as possible in the patient's history, through either administrative data or medical record review. Refer to Table 1A for contraindications and related codes. This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.

Table 1A: Contraindications for Childhood Immunizations

Immunization	Contraindication	ICD-9-CM Code
Any particular vaccine	anaphylactic reaction to the vaccine or its components	999.4
Any particular vaccine	vaccine not rendered due to contraindication	V64.0
DTP/DTaP	encephalopathy within 7 days of previous dose of DTP	323.5
OPV	HIV-infected or household contact with HIV infection	infection V08 symptomatic 042
OPV and MMR	immunodeficiency, including genetic (congenital) immunodeficiency syndromes	279.0x-279.1x, 279.2-279.9
OPV and MMR	cancer of lymphoreticular or histiocytic tissue	200.xx-202.xx
OPV and MMR	multiple myeloma	203.0x, 203.1x, 203.8x, with a fifth digit of '0' or '1'
OPV and MMR	leukemia	204.xx-208.xx, with a fourth digit of '0', '1', '2', '3', '8' or '9'; with a fifth digit of '0' or '1'
MMR	anaphylactic reaction to egg ingestion or streptomycin	995.68, E930.6
IPV	anaphylactic reaction to egg ingestion or neomycin	995.68, E930.8
Hib	none identified	
hepatitis B	anaphylactic reaction to common baker's yeast	995.69

* MMWR. Jan 28, 1994. Vol. 43. No. RR-1.

ADOLESCENT IMMUNIZATION STATUS

New Measure

Description

The percentage of Medicaid and commercially enrolled adolescents whose 13th birthday was in the reporting year, who were continuously enrolled for 12 months immediately preceding their 13th birthday and who received a second dose of MMR by age 13. Members who have had no more than one break in enrollment of up to 45 days during the 12 months preceding their 13th birthday should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify adolescents who turned 13 years old during the reporting year and claims/encounter data to identify adolescents who received a second dose of MMR by age 13. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all enrolled adolescents whose 13th birthday was in the reporting year, who were members of the health plan as of their 13th birthday, who were continuously enrolled for 12 months immediately preceding their 13th birthday and who were not contraindicated for MMR. Members who have had no more than one break in enrollment of up to 45 days during the 12 months preceding their 13th birthday should be included in this measure.

Numerator: The number of adolescents in the denominator for each of the two populations (Medicaid and commercial) who received a second dose of MMR by age 13 (see CPT-4 procedure codes below) or had a seropositive test result for measles, mumps or rubella by their 13th birthday. Health plans need only identify one MMR for this measure and should count members who are identified as having one dose of MMR administered between ages 4 through 12 years.

Measles (CPT-4 codes 90705 or 90707 or 90708 or 90710)

Mumps (CPT-4 codes 90704 or 90707 or 90709 or 90710)

Rubella (CPT-4 codes 90706 or 90707 or 90708 or 90709 or 90710)

Hybrid Method Specification

Calculation: This specification uses membership data to identify adolescents who turned 13 years old during the reporting year and claims/encounter data and/or medical record review to identify adolescents who received a second dose of MMR by age 13. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the plan's eligible populations. Eligible members include,

respectively, Medicaid enrolled adolescents and commercially enrolled adolescents who turned 13 years old during the reporting year, who were members of the plan as of their 13th birthday, who were continuously enrolled for 12 months immediately preceding their 13th birthday and who were not contraindicated for MMR. Members who have had no more than one break in enrollment of up to 45 days during the 12 months preceding their 13th birthday should be included in this measure.

Numerator: The number of adolescents in the denominator for each of the two populations (Medicaid and commercial) who received a second dose of MMR or a seropositive test result for measles, mumps or rubella by age 13, as documented by administrative data (see CPT-4 procedure codes below) or medical record review.

Measles (CPT-4 codes 90705 or 90707 or 90708 or 90710)

Mumps (CPT-4 codes 90704 or 90707 or 90709 or 90710)

Rubella (CPT-4 codes 90706 or 90707 or 90708 or 90709 or 90710)

Note: *For immunization information obtained from patient history, plans may count the immunization in HEDIS reports if the medical record contains the following information: an author-identified and dated immunization history or an author-identified note indicating the place of service, the name(s) of the specific antigen and the date the immunization(s) was given. Entries made in the medical record at the time immunization(s) was given must include either an author-identified note indicating the name(s) of the specific antigen and the date the immunization(s) was given, or the vaccine lot number. A certificate of immunization prepared by an authorized health care provider or agency must include the specific dates and types of immunizations administered. (Refer to the note below on transferred records.) All medical record entries must be dated by the member's 13th birthday (i.e., entries made retroactively may not be counted). The following do not constitute sufficient evidence of immunization for HEDIS reporting:*

- *A note that the "member is up-to-date" with all immunizations, without a listing of the dates all immunizations were given and the names of the immunization agents.*
- *Records transferred from a previous health care provider or agency without a note that the authorized health care provider, to whom the records were transferred, has reviewed them.*

Notes

- Hepatitis B, varicella and tetanus and diphtheria (Td) vaccinations are not required for 1996 reporting. The 1997 Recommended Childhood Immunization Schedule recommends that these vaccinations be administered to adolescents by age 13 years. The Td vaccine is being considered for 1997 reporting. The hepatitis B and varicella vaccinations will be phased-in and required for 1997 reporting. Specifically, documentation of one hepatitis B vaccine by the child's 13th birthday and either one varicella vaccine or documented history of the chicken pox by age 13 will be required.
- We recognize that without identifying the first and second MMR, health plans will be unable to verify that an MMR administered between ages 4 through 12 years is the second MMR. Health plans need only identify one MMR for this measure and should count all members who are identified through either administrative data or medical record review as having one dose of MMR administered between ages 4 through 12 years.

- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Adolescents who are identified as being immunocompromised for the MMR vaccine may be excluded from the denominator of this measure. Plans that choose to exclude these immunocompromised adolescents from the denominator of this measure should look as far back as possible in the patient's history, through either administrative data or medical record review, for contraindications. Refer to Table 1B for the listing of contraindications.

Table 1B: Contraindications for Adolescent Immunizations

Immunization	Contraindication	ICD-9-CM Code
Any particular vaccine	anaphylactic reaction to the vaccine or its components	999.4
Any particular vaccine	vaccine not rendered due to contraindication	V64.0
MMR	immunodeficiency, including genetic (congenital) immunodeficiency syndromes	279.0x-279.1x, 279.2-279.9
MMR	cancer of lymphoreticular or histiocytic tissue	200.xx-202.xx
MMR	multiple myeloma	203.0x, 203.1x, 203.8x, with a fifth digit of '0' or '1'
MMR	leukemia	204.xx-208.xx, with a fourth digit of '0', '1', '2', '3', '8' or '9'; with a fifth digit of '0' or '1'
MMR	anaphylactic reaction to egg ingestion or streptomycin	995.68, E930.6

* MMWR. Jan 28, 1994. Vol. 43. No. RR-1.

ADVISING SMOKERS TO QUIT

New Measure

Description

Among Medicaid, commercial and Medicare risk enrolled adults age 18 years and older as of December 31 of the reporting year, who were continuously enrolled during the reporting year, who were either current smokers or recent quitters, and who were seen by a plan provider during the reporting year — the percentage who received advice to quit smoking during the reporting year from a plan provider. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Specifications

Calculation: This specification uses membership data to identify adults age 18 years and older and survey data to identify individuals who had one (or more) visits with a plan provider, who were current smokers or recent quitters and who reported having received advice to quit from a plan provider during the reporting year. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: The denominator for this measure consists of two steps. First, three separate denominators, one for each of the three required calculations, are derived using random samples of Medicaid, commercial and Medicare risk enrolled adults age 18 years and older as of December 31 of the reporting year, who were members of the health plan as of December 31 of the reporting year and who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included. Sampling will be carried out to assure that at least 107 adult smokers who have seen a physician complete the questionnaire.

Second, select those Medicaid, commercial and Medicare risk members, respectively, who responded to the survey indicating that they were either current smokers or recent quitters and that they had one or more visits with a plan provider during the reporting year. This forms the denominator of this measure.

Note: *Current smokers are individuals who smoke cigarettes every day or some days. Recent quitters are individuals who have stopped smoking for less than one year at the time of the survey. Members who respond "Refuse" or "Don't know" to question 2 are dropped from analysis. Members who respond "Refuse" or "Don't know" to question 3 are also dropped from analysis.*

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who reported having received advice to quit from a plan provider during the reporting year as determined through response to all of the following questions:

1. Have you ever smoked at least 100 cigarettes in your entire life?
   (Those answering "yes" are classified as "ever smokers" and would go to question 2; those answering "no" or "don't know/refused" would be done with the smoking survey.)

2. Do you now smoke every day, some days or not at all?
   (Those answering "every day" or "some days" are classified as current smokers and would go to question 4; those answering "not at all" are classified as former smokers and would go to question 3; those answering "don't know/refused" would be done with the smoking survey.)
3. How long has it been since you quit smoking cigarettes?
   (Those responding as having quit <1 year are classified as recent quitters and would go to question 4; those answering as having quit ≥ 1 year or don't know/refused would be done with the smoking survey.)
4. During the past 12 months, how many times have you visited a doctor or other health professional in your plan (do not count overnight hospital visits)?
   (Those responding one or more visits are classified as having been seen in the plan in the past year and would go to question 5; those responding "none" would be done with the smoking survey.)
5. On how many of these visits were you advised to quit smoking by a doctor or other health professional in your plan?
   (Those responding one or more times are classified as smokers who have received medical advice to quit; those responding "none" should be classified as smokers who have not received medical advice to quit.)

Notes

- Any health care provider who is affiliated with the health plan may provide medical advice to quit smoking (e.g., registered nurses, nurse practitioners, physician assistants, physicians, etc.).
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for health plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- For the commercial population, the five survey questions comprising Advising Smokers to Quit will be included in the Member Satisfaction Survey contained in the Satisfaction with the Experience of Care domain. The information will be collected for Medicare beneficiaries through the Consumer Assessments of Health Plans Study (CAHPS) Medicare survey. The five questions will also be part of the CAHPS Medicaid survey. The CAHPS surveys are expected to be available in March 1997.

FLU SHOTS FOR OLDER ADULTS

New Measure

Description

The percentage of Medicare risk members age 65 years and older as of January 1 of the reporting year who were continuously enrolled during the reporting year and who received an influenza vaccination during the last four months of the reporting year (i.e., from September 1 through December 31 of the reporting year). Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Specifications

Calculation: This specification uses membership data to identify adults, age 65 years and older as of January 1 of the reporting year. Survey data is used to identify individuals who received an influenza vaccination during the last four months of the reporting year.

Denominator: A random sample of Medicare risk enrolled adults, age 65 years and older as of January 1 of the reporting year, who were members of the health plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure. Sampling will be carried out to assure at least 411 respondents in the denominator.

Numerator: The number of members in the denominator who reported having received an influenza vaccination during the last four calendar months of the reporting year (i.e., from September 1 through December 31 of the reporting year) as determined through response to the following questions:

1. Did you get a flu shot last year (i.e., in 199X)? (Circle one)

   a. Yes
   b. No
   c. Don't remember

   (Those answering "yes" should proceed to question 2; those answering "no" or "don't remember" would be done with the HMO influenza survey and should not be counted in the numerator.)

2. In what month did you get your flu shot? (Circle one)

   a. January 199X
   b. February 199X
   c. March 199X
   d. April 199X
   e. May 199X
   f. June 199X
   g. July 199X
   h. August 199X
   I. September 199X
   j. October 199X
   k. November 199X
   l. December 199X
   m. Don't remember

   (Those responding "September 199X," "October 199X," "November 199X" or "December 199X" should proceed to question 3 and <u>should</u> be counted in the numerator;

*those responding "January 199X," "February 199X," "March 199X," "April 199X," "May 199X," "June 199X," "July 199X," "August 199X" or "Don't remember" should proceed to question 3, but **should not** be counted in the numerator.*

3. Where did you go to get your flu shot? (Circle one)

   a. HMO flu clinic
   b. Clinic outside of HMO
   c. Senior Center
   d. Primary care doctor's office
   e. County Health Department
   f. Private doctor's office not affiliated
   g. Military facility (e.g., Veterans with the planAdministration)
   h. A store (name of store_____)
   i. Other _____
   j. Don't remember

Notes

- Health plans should not exclude individuals with a diagnosis of influenza during the reporting year or previous years from this measure.
- Plans must use the Consumer Assessments of Health Plans Study (CAHPS) for the Medicare risk population. The specifications for the Medicare version of the CAHPS survey will contain detailed instructions, including sampling guidelines.
- Plans should substitute the reporting year (e.g., 1996) for all instances in which, "199X" is stated.
- Influenza vaccinations rendered in any setting should count toward the measure (e.g., inpatient, outpatient, SNF).
- This measure is not applicable to the commercial or Medicaid populations because the number of individuals age 65 years and older whose primary coverage is commercial or Medicaid is extremely small. It is therefore not feasible to collect this measure for those populations.
- Plans may identify and exclude the following individuals from the denominator. Plans that choose to exclude these individuals should look back as far as possible in the member's history for these exclusions.
  - Individuals residing in hospice care (UB-92 "Type of Bill" code: 81X or 82X; UB-92 "Revenue" code: 115, 125, 135, 145, 155, 650, 651, 652, 655, 656, 657 or 659).
  - Individuals with an allergy to eggs (ICD-9-CM code: V15.0).
  - Individuals with a history of allergy to the flu vaccine (ICD-9-CM code: V64.0).
  - Individuals with a history of Guillain-Barre Syndrome (ICD-9-CM code: 357.0).

BREAST CANCER SCREENING

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *Age range has been expanded to include individuals up to age 69 years.*
- *This measure, which was optional in Medicaid HEDIS, is now required for the Medicaid and Medicare risk populations.*
- *An exclusionary rule has been added for women who are identified as having had radical bilateral mastectomies.*

Description

The percentage of Medicaid, commercial and Medicare risk women age 52 through 69 years, who were continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify women age 52 through 69 years and claims/encounter data to identify those women who received one or more mammograms during the reporting year or the year prior to the reporting year. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using all enrolled women age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who have had one (or more) mammogram(s) during the reporting year or the year prior to the reporting year. A woman is considered to have had a mammogram if a submitted claim/encounter meets any of the following criteria:

CPT-4 code: 76090 or 76091 or 76092

OR

Revenue code: 401 or 403

OR

ICD-9-CM procedure code: 87.37 or 87.36

OR

Revenue code: 320 or 400 in conjunction with the following breast-related ICD-9-CM diagnosis codes: 174.xx, 198.81, 217, 233.0, 611.72, 793.8, V10.3, V76.1.

Hybrid Method Specification

Calculation: This specification uses membership data to identify women age 52 through 69 years. Claims/encounter data and/or medical record review is used to identify those women who received one or more mammograms during the reporting year or the year prior to the reporting year. Separate calculations are required for the Medicaid, commercial, and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members from the plan's eligible populations. Eligible members include Medicaid enrolled women or commercially enrolled women or Medicare risk enrolled women age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Numerator: The number of enrolled women in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who have had one (or more) mammogram(s) during the reporting year or the year prior to the reporting year as documented through either administrative data or medical record review. Documentation in the medical record must include, at a minimum, an author-identified note indicating the date the mammogram was performed and the result or finding.

Notes

- Plans may exclude from the denominator those women who are identified as having had a radical bilateral mastectomy. Plans that choose to exclude these individuals should look for bilateral mastectomies as far back as possible in the patient's history, through either administrative data or medical record review. Refer to Table 1C for exclusionary codes. This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

Table 1C: Breast Cancer Screening Exclusionary Codes

Mastectomy Status	ICD-9-CM Codes	CPT-4 Codes
Surgical codes for mastectomy	85.44	19240-50 **or** 19240 and 09950
	85.46	19200-50 **or** 19200 and 09950
	85.48	19220-50 **or** 19220 and 09950

CERVICAL CANCER SCREENING

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *Medicaid HEDIS continuous enrollment standard of 12 months has been adopted.*
- ➤ *HEDIS 2.5 age specification has been adopted.*
- ➤ *An exclusionary rule has been added for women who are identified as having had a hysterectomy.*

Description

The percentage of Medicaid and commercially enrolled women age 21 through 64 years, who were continuously enrolled during the reporting year, and who received one or more Pap tests during the reporting year or the two years prior to the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify women age 21 through 64 years and claims/encounter data to identify those women who received one or more Pap tests during the reporting year or the two years prior to the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and who were not identified as having had a hysterectomy with no residual cervix. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who have had one (or more) Pap tests during the reporting year or the two years prior to the reporting year. A woman is considered to have had a Pap test if a submitted claim/encounter meets any of the following criteria:

CPT-4 code: 88150 or 88151 or 88155 or 88156 or 88157

OR

Revenue code: 923

OR

Revenue code: 300 or 310 in conjunction with one of the following cervical-related ICD-9-CM diagnosis codes: 180.x, 233.1, 622.x, 795.0, 795.1, V72.3, V76.2

OR

ICD-9-CM procedure code: 91.46

Hybrid Method Specification

Calculation: This specification uses membership data to identify women age 21 through 64 years. Claims/encounter data and/or medical record review is used to identify those women who received one or more Pap tests during the reporting year or the two years preceding the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the plan's eligible populations. Eligible members include all women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and who were not identified as having had a hysterectomy with no residual cervix. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of enrolled women in the denominator for each of the two populations (Medicaid and commercial) who have had one (or more) Pap tests during the reporting year or the two years prior to the reporting year as detected through either administrative data or medical record review. Documentation in the medical record must include, at a minimum, an author-identified note indicating the date the test was performed and the result or finding.

Notes

- Plans may exclude from the denominator those individuals who have been identified as having had a hysterectomy with no residual cervix. Plans that choose to exclude these individuals should look for hysterectomies as far back as possible in the patient's history, through either administrative data or medical record review. Refer to Table 1D for exclusionary codes. This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

Table 1D: Cervical Cancer Screening Exclusionary Codes

Hysterectomy Status	ICD-9-CM Codes	CPT-4 Codes
Surgical codes for hysterectomy	68.4	58150, 58152, 58200
	68.5, 68.51, 68.59	56308, 58260, 58262, 58263, 58267, 58270, 58275, 58280
	68.6	58210
	68.7	58285
	68.8	58240
		59135

PRENATAL CARE IN THE FIRST TRIMESTER

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5, now applies to the Medicaid population as well.*
- ➤ *Continuous enrollment has been changed from 12 months to 44 weeks prior to delivery.*
- ➤ *The age specification has been removed.*

Description

The percentage of Medicaid and commercially enrolled women who delivered a live birth during the reporting year, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

Administrative Data Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of enrolled women who delivered (a) live birth(s) during the reporting year. Encounter data is used to identify those women who received prenatal care during the first trimester. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all women who delivered (a) live birth(s) during the reporting year and who were continuously enrolled in the plan for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of women in the denominator for each of the two populations (Medicaid and commercial) who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to EDC, if known). Refer to Table 1E, which identifies the specifications or markers for early prenatal care obtainable from administrative data. Note that the numerator is calculated retroactively from time of delivery or EDC.

Note: *Table 1E is recommended and should be used by plans as the basis of their search to identify prenatal care visits in the first trimester. Plans may use any of the three rules presented in Table 1E to search for evidence of prenatal care; a woman's record need satisfy only one of the rules. Plans should document their method for identifying prenatal care whether or not these decision rules are followed.*

Hybrid Method Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of enrolled women who delivered (a) live birth(s) during the reporting year. Encounter data and/or medical record review is used to identify those women who received prenatal care during the first trimester. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the plan's eligible populations. Eligible members include all women who delivered (a) live birth(s) during the reporting year, and who were continuously enrolled for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included in this measure.

EFFECTIVENESS

Note: To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of enrolled women in the denominator for each of the two populations (Medicaid and commercial) who had a prenatal care visit 26 to 44 weeks prior to delivery date (or prior to EDC, if known). The visit may be identified through administrative data (see Table 1E) or medical record review. For a prenatal care visit(s) to a midwife or OB provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, and/or echography of a pregnant uterus.

OR

Evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of last menstrual period (LMP) or EDC.

OR

Documentation of LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

For a prenatal care visit(s) to a family practitioner or other primary care provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as screening test in the form of either an obstetrical panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, and/or echography of a pregnant uterus, and evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of LMP or EDC.

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, an antenatal screen, and/or echography of a pregnant uterus, and evidence that a diagnosis of pregnancy has been established in the form of a documented LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

Note that the numerator is calculated retroactively from time of delivery or EDC.

Notes

- For a prenatal care visit to a family practitioner or other primary care provider, documentation in the medical record at the time of the prenatal care visit need not include a complete medical history if the primary care provider is the patient's regular doctor and has documented the patient's medical history elsewhere in the medical record.
- A prenatal care visit to a family practitioner or other primary care provider requires both diagnosis-based and procedure-based evidence of prenatal care to ensure that prenatal care services were rendered in addition to the member's pregnancy status.

- Evidence of prenatal care may be completed during any visit(s) during the first trimester.
- By specifying the population at risk to include only live births, HEDIS captures only a percentage of plan members' pregnancies.
- Live births that occurred in a birthing center should be included in this measure.
- When counting prenatal visits, include visits to physicians, nurse practitioners and midwives, as well as registered nurses provided that evidence of co-signature by a physician is present, if required by state law.
- The numerator includes visits that take place 26 to 44 weeks prior to delivery. Forty-four weeks was specified to ensure inclusion of first trimester visits for women who deliver post-term, thereby recognizing the imprecise nature of estimated delivery dates.
- EDC is calculated by subtracting three months from the first day of the last menstrual period and adding seven days.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Plans may map state-specific HCPCS Level II or Level III codes (i.e., codes beginning with 'W', 'X', 'Y', and 'Z') to the corresponding CPT-4 codes in this measure.

Table 1E: Markers for Early Prenatal Care Obtainable from Administrative Data

Decision Rule 1

Marker Event:	Specifications:
Prenatal care visit to a midwife, OB provider or family practitioner or other primary care provider with documentation of when prenatal care was initiated.	CPT-4 = 59400* or 59510* or 59610* or 59618* or 59425** or 59426**

OR

Decision Rule 2

Marker Event:	Specifications:
Any visit to a midwife or OB provider ***with either*** Procedure-based evidence of prenatal care in the form of screening tests such as an obstetric panel-alone, or torch antibody panel alone or rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing), or ultrasound (echography) of a pregnant uterus. ***OR*** Diagnosis-based evidence of prenatal care in the form of pregnancy-related diagnosis or ICD-9-CM V code for prenatal care.	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with either*** CPT-4 = 80055 alone or 80090 alone or 86762 with 86900 or 86901; ***or*** CPT-4= 76805, 76815, or 76816 ***OR*** ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (5th digit)=3 ***or*** ICD-9-CM = V22.0-V23.9 or V28.x

OR

Decision Rule 3

Marker Event:	Specifications:
Any visit to a family practitioner or other primary care provider ***with both*** Procedure-based evidence of prenatal care in the form of screening tests such as an obstetric panel-alone, or torch antibody panel alone or rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing), or ultrasound (echography) of a pregnant uterus. ***AND*** Diagnosis-based evidence of prenatal care in the form of pregnancy-related diagnosis or ICD-9-CM V code for prenatal care.	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with both*** CPT-4 = 80055 alone or 80090 alone or 86762 with 86900 or 86901; ***or*** CPT-4= 76805, 76815, or 76816 ***AND*** ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (5th digit)=3 ***or*** ICD-9-CM = V22.0-V23.9 or V28.x

OR

Decision Rule 4

Marker Event:	Specifications:
Any visit to a family practitioner or other primary care provider ***with*** Diagnosis-based evidence of prenatal care in the form of a documented LMP or EDC with either a complete obstetrical history or risk assessment and counseling/education.	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with*** Internal plan code for an obstetrical history or risk assessment and counseling/education (if applicable).

* Generally these codes are used on the date of delivery, not the first date for OB care, so this code will be useful only if the claim form indicates when prenatal care was initiated.

** This code will be useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

LOW BIRTH-WEIGHT BABIES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ***This measure, from HEDIS 2.5 and Medicaid HEDIS, is not required for the 1996 reporting year. It is being deferred because of the persistent problems with risk adjustment and ability to identify low birth-weight infants based on administrative data. Improved specifications will be developed, and the measure will be required for the 1997 reporting year.***
- ***HEDIS 2.5 continuous enrollment standard of 12 months has been adopted.***
- ***The age limits for the mother applied in HEDIS 2.5 have been removed.***

Description

Two birth-weight measures are to be calculated: 1) the percentage of infants whose birth weight is less than 1,500 grams and 2) the percentage of infants whose birth weight is less than 2,500 grams. Babies in the very low birth-weight category are a subset of the babies in the low birth-weight category. Female members who have been continuously enrolled for 12 months prior to delivery and who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses hospital discharge data to identify the number of live deliveries to enrolled women during the reporting year. Hospital discharge data and/or birth certificate data identifies infants weighing less than 1,500 grams and/or less than 2,500 grams. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all live births delivered to women who were continuously enrolled for 12 months prior to delivery. Female members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

1: Identify women who have had at least one live birth during the reporting year. These are deliveries with one of the following codes:

DRG codes: 370-375. Only deliveries resulting in <u>live</u> births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

2: Of these women, include those who were continuously enrolled for 12 months prior to delivery.

3: Include in the denominator all live births (i.e., a count of all live babies, not deliveries) to the women who were continuously enrolled for 12 months prior to delivery. Discharge abstracts for live newborns have a principal ICD-9-CM diagnosis code of V30.x-V39.x.

Numerator: The numerator to calculate the very low birth-weight rate is the number of infants weighing less than 1,500 grams. The numerator to calculate the low birth-weight rate is the number of infants in the denominator with birth weights of less than 2,500 grams. Birth-weight information can be obtained from the child's discharge abstract, medical record or birth certificate.

If the baby's discharge abstract data are used, identify low birth-weight infants by the fifth digit of ICD-9-CM codes 764 (slow fetal growth and fetal malnutrition) and 765 (disorders relating to short gestation and unspecified low birth weight).

The numerator to calculate the very low birth-weight rate is the number of babies in the denominator for each of the two populations (Medicaid and commercial) with an ICD-9-CM code of:

764.x1, 764.x2, 764.x3, 764.x4, 764.x5, 765.x1, 765.x2, 765.x3, 765.x4 or 765.x5, where x can be 0, 1, 2 or 9.

The numerator to calculate the low birth-weight rate is the number of babies, reflected in the denominator for each of the two populations (Medicaid and commercial), with

EFFECTIVENESS O

an ICD-9-CM code of:

764.x1, 764.x2, 764.x3, 764.x4, 764.x5, 764.x6, 764.x7, 764.x8, 765.x1, 765.x2, 765.x3, 765.x4, 765.x5, 765.x6, 765.x7 or 765.x8, where x can be 0, 1, 2 or 9.

Notes

- If the reliability of the fifth-digit ICD-9-CM coding of low birth-weight infants is low, plans should consider alternative sources of data (e.g., birth certificates, medical records).
- Include births that occur in birthing centers in the calculation of this measure.
- Some plans do not complete discharge abstracts for newborns discharged at the same time as their mothers. These plans should follow the approximation method described in Table 1F to identify the number of live infants born to the mother. The plan should then develop a method (e.g., one based on birth certificates) to identify infants who had low or very low birth weights. Plans should carefully document their method.
- Low birth weight is an outcome measure that can be influenced by many variables. No adjustment for these variables is made in this measure. Thus, the measure is best trended over time for an individual health plan.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Most plans will want to calculate their low birth-weight rates using hospital discharge abstract data. Because there is concern about the reliability of fifth-digit ICD-9-CM coding on the discharge abstract, we recommend that health plans conduct an internal audit to verify the completeness and accuracy of coded birth-weight data. Specifically, we encourage health plans to select a sample of births and compare the discharge abstract birth-weight information to the medical record. Plans should include the results of the internal audit as a part of their HEDIS reports. If the reliability of the discharge abstract data is low, health plans should consider alternative sources of data (e.g., birth certificates).

Hybrid Method Specification

Because the cost associated with estimating low birth-weight rates through the random sampling of medical records would be prohibitively high, and the low birth-weight rate for the majority of plans is very low (e.g., around 5%) that using a sample to calculate this measure results in a relative margin of error so great that the reported rate would be meaningless, only an administrative data specification for this measure is provided.

Table 1F: Method to Approximate the Number of Newborns in the Absence of Newborn Claims

After excluding all deliveries without a live birth (V27.1, V27.4, V27.7, V35), classify the remaining deliveries according to the following algorithm:

	ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code		ICD-9 Code	# Live Newborns
If Dx code	651.3	OR	V27.0	OR	V27.3	OR	V30.xx	OR	V32.xx	OR	V35.xx							Then count as one newborn
If Dx code	651.0	OR	651.4	OR	651.5	OR	651.6	OR	V27.2	OR	V27.6	OR	V31.xx	OR	V33.xx	OR	V36.xx	Then count as two newborns
If Dxcode	651.1	OR	651.9	OR	V27.5	OR	V37.xx											Then count as three newborns
If Dx code	651.2	OR	V34.xx															Then count as four newborns
If Dx code	651.8																	Then count as five newborns

If more than one of the above codes exists in the same discharge record, resolve conflicts as follows:

1. If a code on a discharge record indicates one newborn (codes on the first row = 651.3, V27.0, V27.3, V30.xx or V32.xx) but another code on the discharge record indicates two or three newborns (codes on the second and third row), then plans should use the higher number of newborns. For example, 651.3 indicates one newborn and code 651.0 indicates two newborns. Plans should count two newborns.
2. On the other hand, if a code indicates one, two or three newborns (codes on first, second and third row) and another code indicates four or five newborns, then plans should use the lower number. For example, 651.1 indicates three newborns and code 651.8 indicates five newborns. Plans should use only three newborns in their count.
3. If a plan does not have any of the above codes or a system to determine the number of newborns, it should count only one newborn for every delivery.

CHECK-UPS AFTER DELIVERY

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, optional in Medicaid HEDIS, is now required for Medicaid and commercial populations.*

Description

The percentage of Medicaid and commercially enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled 42 days after delivery, with no breaks in enrollment, who had a postpartum visit by the 42nd day after delivery.

Administrative Data Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of women who delivered (a) live birth(s) during the reporting year. Claims/encounter data is used to identify those women who received postpartum care. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all enrolled women who delivered (a) live birth(s) from January 1 through November 18 of the reporting year and who were continuously enrolled for 42 days after delivery, with no breaks in enrollment.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of women in the denominator for each of the two populations (Medicaid and commercial) who had a postpartum visit by the 42nd day after delivery. A woman is considered to have had a postpartum visit if a submitted claims/encounter includes any of the following codes and has a date of service between the hospital discharge date and the 42nd day after the delivery.

ICD-9-CM codes:

V24.1	Lactating mother (supervision of lactation)
V24.2	Routine postpartum follow-up

OR

CPT-codes:

59400	Vaginal delivery: Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only (separate procedure)
59510	Cesarean delivery: Routine obstetric care including antepartum care, cesarean delivery and postpartum care
59515	Cesarean delivery, including postpartum care
59610	Routine obstetric care, including postpartum care
59614	Routine obstetric care, including postpartum care
59618	Routine obstetric care, including postpartum care
59622	Cesarean delivery, including postpartum care

Hybrid Method Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of women who delivered (a) live birth(s) during the reporting year. Claims/encounter data and/or medical record review is used to identify those women who received postpartum care by the 42nd day after delivery. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid members and 411 commercial members from the health plan's eligible populations. Eligible members include Medicaid and commercially enrolled women who delivered (a) live birth(s) from January 1 through November 18 of the reporting year and who were continuously enrolled for 42 days after delivery, with no breaks in enrollment.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of enrolled members in the denominator for each of the two populations (Medicaid and commercial) who had a postpartum visit by the 42nd day after delivery as documented through either administrative data medical record review.

Notes

- By specifying the denominator population to include only women with live births, this measure captures only a percentage of a plan members' pregnancies.
- Women who delivered in a birthing center should be included in this measure.
- When counting postpartum visits, include visits to physicians, nurse practitioners and midwives.

TREATING CHILDREN'S EAR INFECTIONS

New Measure

Description

The percentage of Medicaid and commercially enrolled children who were diagnosed with an uncomplicated episode of acute otitis media during the reporting year, who were continuously enrolled for six months immediately preceding the diagnosis or, if the child was younger than six months old at the time of diagnosis, continuously enrolled since birth, and who were dispensed an antibiotic other than a preferred antibiotic. The rate reported is 1 – (numerator/denominator).

Health plans should only count the first uncomplicated episode of acute otitis media occurring during the reporting year, and no child should be counted more than once in this measure. Plans should count in this measure only those members who have had no breaks in enrollment during the six months preceding the first episode or, if the child was younger than six months old at the time of diagnosis, since birth.

Note: *The inverted rate is reported in this measure to be consistent with other Effectiveness of Care measures: a higher rate indicates better performance.*

Administrative Data Specification

Calculation: This specification uses membership data and claims/encounter to identify children at least six weeks old but less than 60 months (five years) old who were diagnosed with an uncomplicated episode of acute otitis media during the reporting year. Pharmacy data is used to identify children who were dispensed an antibiotic other than a preferred antimicrobial agent. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived from the number of enrolled children who meet the following criteria:

- Who were diagnosed during the reporting year with an uncomplicated episode of acute otitis media. Plans should use the following ICD-9-CM principal diagnosis codes to identify an uncomplicated episode of acute otitis media: 382.4, 382.9, 382.00 or 382.01.

  AND

- Who were at least six weeks old but less than 60 months (five years) old at the time of diagnosis.

  AND

- Who were continuously enrolled for six months immediately preceding the diagnosis or, if the child was younger than six months old at the time of diagnosis, since birth.

  AND

Who were not identified as having a diagnosis of an infectious comorbidity or underlying disorder of immunity (refer to Table 1G) occurring on the same date of service or within six months prior to the diagnosis of acute otitis media.

AND

Who were not identified as having a previous diagnosis of acute otitis media within the preceding six months (i.e., ICD-9-CM diagnosis codes 382.4, 382.9, 382.00 or 382.01).

Note: Health plans should use only the first uncomplicated episode in the reporting year to calculate this measure.

Numerator: The number of children in the denominator for each of the two populations (Medicaid and commercial) who were dispensed an antibiotic other than a preferred antimicrobial (either amoxicillin or trimethoprim-sulfamethoxazole). The prescription for any antibiotic other than amoxicillin or trimethoprim-sulfamethoxazole should have been dispensed within two days of the diagnosis to ensure that it was prescribed for the acute otitis media episode. The following prescriptions correspond to trimethoprim-sulfamethoxazole and do not count in the numerator: Bactrim, Septra and Sulfatrim Suspension.

Rate: 1 – (Numerator/Denominator).

Hybrid Method Specification

Calculation: This specification uses membership and claims/encounter to identify children at least six weeks old but less than 60 months (five years) old who were diagnosed with an uncomplicated episode of acute otitis media during the reporting year. Pharmacy data and/or medical record review is used to identify children who were dispensed an antibiotic other than a preferred antimicrobial agent. Separate calculations are required for the Medicaid and commercial populations.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using random samples of 411 Medicaid enrolled children and 411 commercially enrolled children who meet the following criteria:

Who were diagnosed during the reporting year with an uncomplicated episode of acute otitis media. Plans should use the following ICD-9-CM principal diagnosis codes to identify an uncomplicated episode of acute otitis media: 382.4, 382.9, 382.00 or 382.01.

AND

Who were at least six weeks old but less than 60 months (five years) old at the time of diagnosis.

AND

Who were continuously enrolled for six months immediately preceding the diagnosis or, if the child was younger than six months old at the time of diagnosis, since birth.

AND

EFFECTIVENESS

Who were not identified as having a diagnosis of an infectious comorbidity or underlying disorder of immunity (refer to Table 1G) occurring on the same date of service or within six months prior to the diagnosis of acute otitis media.

AND

Who were not identified as having a previous diagnosis of acute otitis media within the preceding six months (i.e., ICD-9-CM diagnosis codes 382.4, 382.9, 382.00 or 382.01).

Note: Health plans should use only the first uncomplicated episode in the reporting year to calculate this measure.

Numerator: The number of children in the denominator for each of the two populations (Medicaid and commercial) who were dispensed an antibiotic other than a preferred antimicrobial (either amoxicillin or trimethoprim-sulfamethoxazole) as documented through either the pharmacy data or medical record review. The prescription for any antibiotic other than amoxicillin or trimethoprim-sulfamethoxazole should have been dispensed within two days of the diagnosis to ensure that it was prescribed for the acute otitis media episode. The following prescriptions correspond to trimethoprim-sulfamethoxazole and do not count in the numerator: Bactrim, Septra and Sulfatrim Suspension.

Rate: 1 – (Numerator/Denominator).

Notes

- Plans should only include children in the denominator for whom the plan manages or provides a pharmacy benefit in order to accurately identify children who were not dispensed a preferred antibiotic and document the percentage of children who were at least six weeks old but less than 60 months old during the reporting year for whom the plans manages or provides a pharmacy benefit.
- A child who is not treated with any antibiotic should be counted in the denominator but should not be counted in the numerator.
- Plans may identify those children for whom a previous diagnosis of otitis media occurred within the continuous enrollment period and exclude them from the measure.
- Plans should only count the first episode of acute otitis media occurring during the reporting year. No child should be counted more than once in this measure.
- Plans may exclude from the denominator children who are identified as either having an allergy to amoxicillin and trimethoprim-sulfamethoxazole or having an infectious comorbidity or underlying immunity disorder on the same date of service or within six months prior to the diagnosis of acute otitis media as documented through either administrative data or medical record review. Refer to Table 1G for the list of comorbidities or underlying immunity disorders and related codes.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

Table 1G: Infectious Comorbidities or Underlying Disorders of Immunity

Infection	ICD-9-CM Code
Intestinal infection	001.x-002.x, 003.0-003.1, 003.2x, 003.8-003.9, 004.x-007.x, 008.xx, 009.x
Tuberculosis	011.xx-018.xx
Zoonotic bacterial disease	020.x-023.x, 024, 025, 026.x-027.x
Leprosy & other mycobacterial diseases	030.x-031.x
Diphtheria	032.xx
Whooping cough	033.x
Erysipelas	035
Meningococcal infection	036.xx
Septicemia	038.xx
Actinomycotic disease	039.x
Other bacterial infection	040.xx, 041.xx
HIV infection	042
Chlamydial disease	076.x, 077.xx-079.xx
Rickettsioses & arthropod disease	080, 081.x1-083.x, 087.x-088.x
Syphilis & other venereal diseases	090.xx-091.xx, 092.x, 093.xx-094.xx, 095.x, 096, 097.x, 098.0, 098.1x, 098.2, 098.3x, 098.4x, 098.5x, 098.6, 098.7, 098.8x, 099.0, 099.1, 099.2, 099.3, 099.4x, 099.5x, 099.8, 099.9
Other spirochetal disease	100.x, 101, 102.x-104.x
Other infectious & parasitic diseases	130.x, 131.0x, 131.8, 131.9, 136.x
Malignant neoplasm	140.x-165.x, 170, 170.x, 171.x, 172.x, 173.x, 174.x, 175.x, 176.x, 179, 180.x, 181, 182.x, 183.x, 184.x, 185, 186.x, 187.x, 188.x, 189.x, 190.x, 191.x, 192.x, 193, 194.x, 195.x, 196.x, 197.x, 198.x, 199.x, 200.xx-202.xx, 203.x0-208.x0, 203.x1-208.x1, 230.x -235.x, 236.xx, 237.xx, 238.x-240.x
Immune disease	279.0x-279.1x, 279.2-279.4, 279.8, 279.9
Sickle cell disease and other hemoglobinopathy	282.6x, 282.7
Disease of white blood cells	288.x
Other disease of spleen	289.5x
Bacterial meningitis	320.0, 320.1, 320.2, 320.3, 320.7, 320.8x, 320.9
Meningitis	321.x-323.x
Intracranial and intraspinal abscess	324.0, 324.1, 324.9
Purulent endophthalmitis	360.0x-360.1x
Infection of conjunctiva	372.0x-372.3x
Inflammation of eyelids	373.xx
Disorders of the orbit	376.0x-376.1x
Disorders of external ear	380.0x-380.2x
Chronic otitis media	381.1x-381.2x, 381.3, 381.5x-381.6x, 381.7, 381.8x, 381.9, 382.1-382.3
Mastoiditis	383.xx
Disorders of tympanic membrane NEC	384.0x, 384.1, 384.2x, 384.8x, 384.9

Table 1G: Infectious Comorbidities or Underlying Disorders of Immunity

Infection	ICD-9-CM Code
Disorders middle ear and mastoid NEC	385.0x-385.3x, 385.8x, 385.9
Otorrhea	388.6x
Acute rheumatic fever	390, 391.x, 392.0, 392.9, 393, 398.0, 398.9x
Pericarditis/Endocarditis/Myocarditis	420, 420.0, 420.9x, 421.x, 422.0, 422.9x, 429.0
Acute Laryngitis/Tracheitis	464.0, 464.1x-464.3x, 464.4
Acute bronchiolitis	466.1
Chronic pharyngitis and nasopharyngitis	472.1, 472.2
Chronic sinusitis	473.0, 473.1, 473.2, 473.3, 473.8, 473.9
Chronic T&A disease	474.0, 474.1x, 474.2, 474.8, 474.9
Peritonsillar abscess	475
Chronic laryngitis and laryngotracheitis	476.0, 476.1
Other respiratory disease	478.0, 478.1, 478.2x, 478.3x, 478.4-478.6, 478.7x, 478.8, 478.9
Pneumococcal pneumonia	481
Other bacterial pneumonia	482.0, 482.1, 482.2, 482.3x, 482.4, 482.8x, 482.9
Pneumonia other specified organism	483.0, 483.8
Pneumonia in other infectious disease	484.x
Bronchopneumonia	485
Pneumonia unspecified	486
Chronic bronchitis	491.0, 491.1, 491.2x, 491.8, 491.9
Bronchiectasis	494
Chronic airway obstruction, NEC	496
Pleurisy	511.0, 511.1, 511.8, 511.9
Lung abscess	513.0, 513.1
Other respiratory system diseases	519.x
Oral soft tissue infection	528.3
Appendicitis	540.0, 540.1, 540.9, 541, 542
Cholecystitis	574.6x-574.8x, 575.0, 575.1x
Cholangitis	576.1
Pancreatitis	577.0, 577.1, 577.9
Acute glomerulonephritis	580.0, 580.4, 580.8x, 580.9
Kidney infection	590.0x-590.1x, 590.2, 590.3, 590.8x, 590.9
Cystitis	595.0-595.4, 595.8x, 595.9

Table 1G: Infectious Comorbidities or Underlying Disorders of Immunity

Infection	ICD-9-CM Code
Urethritis	597.0, 597.8x
Urinary tract infection	599.0
Orchitis and epididymitis	604.0, 604.9x
Infection of the male genitals	607.1, 607.2, 608.4
Female pelvic inflammatory disease	614.x, 615.0, 615.1, 615.9
Other female genital inflammatory disease	616.0, 616.1x, 616.2-616.4, 616.5x, 616.8, 616.9
Infection of skin and soft tissue	680.x, 681.xx, 682.x, 683, 684, 685.0, 685.1, 686.0, 686.1, 686.8, 686.9
Infectious arthropathy	711.0x, 711.4x, 711.9x
Infectious myositis	728.0
Fasciitis, unspecified	729.4
Osteomyelitis	730.xx

BETA BLOCKER TREATMENT AFTER A HEART ATTACK

New Measure

Description

The percentage of Medicaid, commercial and Medicare risk members age 35 years and older during the reporting year, who were hospitalized and discharged alive during the reporting year with a diagnosis of acute myocardial infarction (AMI) and who received a prescription for beta blockers upon discharge.

Administrative Data Specification

Calculation: This specification uses membership data and claims/encounter data to identify adults age 35 years and older during the reporting year who were hospitalized and discharged alive during the reporting year with a diagnosis of AMI. Hospital discharge abstract data and pharmacy data are used to identify a prescription for beta blockers at the time of discharge. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using all members age 35 years and older as of December 31 of the reporting year who were hospitalized and discharged alive during the reporting year with a principal diagnosis of AMI (ICD-9-CM code 410.xx) and who were not identified as having a contraindication to beta blockers. Refer to Table 1H for a list of conditions and related ICD-9-CM codes for exclusions from the measure.

Numerator: The number of adults in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who received a prescription for beta blockers within seven days after discharge from the hospital with a diagnosis of AMI or within 30 days prior to the hospitalization for AMI. The following prescriptions correspond to beta blockers and count toward this measure:

Acebutolol HCl, Atenolol, Betaxolol HCl, Bisoprolol Fumarate, Carteolol HCl, Esmolol HCl, Labetalol HCl, Metoprolol Succinate, Metoprolol Tartrate, Nadolol, Penbutolol Sulfate, Pindolol, Propranolol HCl, Sotalol Hcl and Timolol Maleate.

Hybrid Method Specification

Calculation: This specification uses membership data and claims/encounter data to identify adults age 35 years and older during the reporting year who were hospitalized and discharged alive during the reporting year with a diagnosis of AMI. Hospital discharge abstract data, pharmacy data and/or medical record review are used to identify a prescription for beta blockers at the time of discharge. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members drawn from the health plan's eligible populations. Eligible members include, respectively, Medicaid adults, commercial adults and Medicare risk adults age 35 years and older as of December 31 of

the reporting year who were hospitalized and discharged alive during the reporting year with a principal diagnosis of AMI (ICD-9-CM code 410.xx), and who were not identified as having a contraindication to beta blockers. Refer to Table 1H for a listing of conditions and related ICD-9-CM diagnosis codes for exclusions from the measure.

Numerator: The number of adults in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who received a prescription for beta blockers within seven days after discharge from the hospital with a diagnosis of AMI or within 30 days prior to the hospitalization for AMI as documented through either administrative data or medical record review. The following prescriptions correspond to beta blockers and count toward this measure:

Acebutolol HCl, Atenolol, Betaxolol HCl, Bisoprolol Fumarate, Carteolol HCl, Esmolol HCl, Labetalol HCl, Metoprolol Succinate, Metoprolol Tartrate, Nadolol, Penbutolol Sulfate, Pindolol, Propranolol HCl, Sotalol HCl and Timolol Maleate.

Notes

- Plans are strongly encouraged to exclude from the denominator members who are identified through either administrative data or medical record review as having a contraindication to beta blocker therapy, because the number of individuals with contraindications is likely to be relatively large. Refer to Table 1H for the listing of contraindications to beta blocker therapy.
- Plans are strongly encouraged to exclude from the denominator members who are identified through either administrative data or medical record review as having had a previous failure with beta blocker therapy.
- In cases where patients have had more than one episode of AMI (as indicated by ICD-9-CM diagnosis code 410.xx) during the reporting year, only the first episode should be included in this measure. Any episode with ICD-9-CM diagnosis code 410.x2 (AMI, subsequent episode of care) should be excluded from this measure.
- Plans should document the percentage of members in the denominator for whom the plan manages or provides the pharmacy benefit. The denominator of this measure includes all members who have been diagnosed during the reporting year with an AMI regardless of whether the plan manages or provides the pharmacy benefit because the number of members eligible for this measure is likely to be small.

Table 1H: Contraindications to Beta Blockers

Description of Contraindication	ICD-9-CM Code
Insulin dependent diabetes mellitus	250.x1, 250.x3
History of asthma	493.xx
Heart block > 1 degree	426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.54, 426.7
Sinus bradycardia	427.81
CHF	398.91, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 404.03, 404.13, 404.93, 428.0
Left ventricular dysfunction	428.1
COPD	491.20, 491.21, 492.0, 492.8, 496, 518.2, 506.4

EYE EXAMS FOR PEOPLE WITH DIABETES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *The upper age limit has been removed.*
- ➤ *Specifications for the denominator have been modified: Method A in Medicaid HEDIS and Method 1 in HEDIS 2.5 have been deleted.*
- ➤ *This measure, optional in Medicaid HEDIS, is now required for Medicaid members.*
- ➤ *This measure now applies to the Medicare risk population.*

Description

The percentage of Medicaid, commercial and Medicare risk members with diabetes (Type I and Type II) age 31 years and older, who were continuously enrolled during the reporting year, and who had a retinal examination during the reporting year. Enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses ambulatory claims/encounter data or pharmacy data to identify members with diabetes and ambulatory claims/encounter data to identify members who received a retinal exam during the reporting year. Separate calculations are required for the Medicaid, commercial, and Medicare risk populations.

Note: *Method A from Medicaid HEDIS and Method 1 from HEDIS 2.5 were deleted in favor of what was referred to as Method B or Method 2, because Method B/2 is preferred to capture diabetics treated through diet and exercise.*

Denominator: Three separate denominators, one for each of the three required calculations, are derived using all members age 31 years or older as of December 31 of the reporting year, who were members of the health plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year (including enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year) and identified as diabetic:

Those who were dispensed insulin and/or oral hypoglycemics during the reporting year on an ambulatory basis.

OR

Those who had two face-to-face encounters in an ambulatory setting or one face-to-face encounter in an inpatient or emergency room setting with a diagnosis of diabetes (ICD-9-CM code 250.xx, 357.2, 362.0x or 366.41). Use the following codes to identify ambulatory, inpatient and ER encounters:

UB-92 revenue codes (Form Locator 42):

10X, 11X, 12X, 13X, 14X, 15X, 16X, 17X, 20X, 21X, 22X, 45X, 49X, 50X, 51X, 52X, 53X, 55X, 57X, 58X, 59X, 65X, 66X, 72X, 76X, 80X, 82X, 83X, 88X, 92X, 94X, 96X, 97X and 98X.

CPT-4 codes:

Office or other outpatient services

99201-99205

99211-99215

99217-99220

99241-99245

99271-99275

99281-99288

Inpatient Services

99221-99223

99231-99233

99238-99239

99251-99255

99261-99263

99291-99292

Prolonged physician service

99354-99357

Preventive medicine

99381-99387

99391-99397

99401-99404

99411-99412

99420-99429

Home services

99341-99343

99351-99353

Comprehensive nursing facility assessments

99301-99303

Subsequent nursing facility care

99311-99313

Domiciliary, rest home or custodial care services

99321-99323

99331-99333

Other evaluation and management services

99499

Ophthalmology and optometry

92002-92014

Note: *Many plans find a high rate of false positives when they use laboratory data to identify diabetics, because diabetes diagnosis codes frequently are reported on laboratory tests used to rule out diabetes. Therefore, laboratory data should not be used to identify diabetics.*

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who have a retinal ophthalmoscopic examination performed by an eye-care professional during the reporting year.

A person is counted as having a retinal ophthalmoscopic examination if he or she has had a claim/encounter with a service date during the reporting year in which one or more of the following services were provided:

CPT-4 codes:

92002	Ophthalmic services, intermediate, new patient
92004	Ophthalmic services, comprehensive, new patient
92012	Ophthalmic services, intermediate, established patient
92014	Ophthalmic services, comprehensive, established patient
92018	Ophthalmic exam, general anesthesia, complete
92019	Ophthalmic exam, general anesthesia, limited
92225	Ophthalmoscopy, extended-initial
92226	Ophthalmoscopy, extended-subsequent
92235	Fluorescein angiography (includes multiframe imaging) with medical diagnostic evaluation
92250	Fundus photography with medical diagnostic evaluation

Hybrid Method Specification

Calculation: This specification uses ambulatory claims/encounter data or pharmacy data to identify members with diabetes. Ambulatory claims/encounter data and/or medical record review are used to identify individuals who received a retinal exam during the reporting year. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members from the plan's eligible populations. Eligible members include Medicaid, commercial and Medicare risk members with diabetes age 31 years or older as of December 31 of the reporting year, who were members as of December 31 of the reporting year and who were continuously

enrolled during the reporting year. Enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure. See the administrative data specification for definition of the diabetic population by ambulatory prescription drug and claim/encounter records.

Numerator: The number of members in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) who received a retinal examination during the reporting year, as documented through either administrative data or medical record review. For medical record review, a retinal examination is documented by:

A note or letter from an ophthalmologist, optometrist or other health care provider summarizing the date the procedure was performed and the results of an evaluation performed by an eye-care professional.

OR

A chart or photograph of retinal abnormalities. If fundus photography was used, there must be documentation in the medical record indicating the date the procedure was performed and evidence that the results were reviewed by an eye-care professional.

OR

An author-identified note, which may be prepared by a primary care provider, indicating the date the procedure was performed and that an ophthalmoscopic exam was completed by an eye-care professional, with results of the exam.

Notes

- The CPM recognizes that the frequency of retinal screening in diabetics is influenced by the type of diabetes and the presence and degree of retinopathy. In summary, annual screening may not be indicated for every diabetic patient. Therefore, one would not necessarily expect a screening rate of 100% in each plan. Ideally, this measure should report diabetic retinal screening stratified on the basis of risk for developing vision-threatening retinopathy. The feasibility and validity of specifications that allow such stratification of the diabetic population will be evaluated during 1997.
- For purposes of this measure, an "eye-care professional" is an optometrist or ophthalmologist.
- This measure calculates the rate of performance of a regular eye exam in a defined patient population. The performance does not demonstrate whether effective treatment was provided to the patient.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

- The likelihood that a member has received a retinal exam based on the presence of the CPT-4 codes cited is uncertain. A number of CPT-4 codes for other ophthalmic services have been excluded. It is unclear whether their exclusion will lead to underreporting of the rate of retinal exams.
- There is consensus among the American Diabetes Association, National Eye Institute, and American Academy of Ophthalmology that dilation of the pupil is necessary to ensure optimal examination of the retina. However, the current coding structure permits us to know only whether an eye exam was performed and not whether the pupil was dilated. This measure represents a minimum rather than an optimum standard, but the CPM believes that it is nonetheless valuable in improving existing preventive eye care for diabetics.
- A plan with as few as 10,000 enrollees would be expected to have at least 100 diabetics.
- Plans that use only pharmacy data to identify their diabetic population should also document the percentage of all their members age 31 years and older for whom the health plan manages or provides a pharmacy benefit.
- Plans may exclude members who, through medical record review, are identified as not being diabetic.

THE HEALTH OF SENIORS

New Measure

Description

The percentages of senior Medicare risk plan members, age 65 years and older, whose self-reported health status has improved, stayed the same or worsened. Change is measured over two years and has two components — mental and physical.

Specifications

Calculation: The SF-36, plus additional items for risk adjustment, will be mailed at the outset and two years later; the additional items are a checklist of morbid conditions, self-evaluated change in status, a three-level income question, number in household, social support, education, race, age and sex. The mental and physical components are scored according to published methodology[1]. The change in the responses from year 1 to year 3 will be compared to an expected change. Individual members will be categorized as 'worse' if the change in their functional scores are negative and larger than expected. They will be classified as 'same' if the change in functional scores are within the expected range, and 'better' if the change in their scores is positive and larger than expected. The resulting percentages in each category will be adjusted for the additional comorbid conditions and socioeconomic factors collected in the survey.

Denominator: A random sample of 1,000 Medicare risk enrolled adults age 65 years and older who have been continuously enrolled for at least six months; these members will be surveyed at baseline and again after two years. For the mental component, the denominator consists of all persons who complete both surveys. For the physical component, the denominator also includes persons who die or who move into long-term facilities and do not return the questionnaire. In these last two cases, the members will be counted as having worsened.

Numerators: Three numerators are calculated using the number of respondents two years later who fall in the following categories.

"Better" — change in functional scores positive and larger than expected

"Same — change in functional scores not larger than expected in either direction

"Worse" — change in functional scores negative and larger than expected

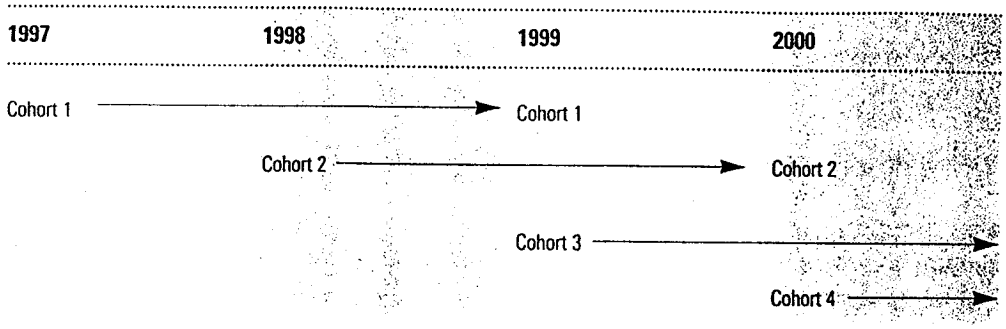
Separate rates are reported for mental and physical scores and will be risk-adjusted as described below, incorporating the additional items collected.

Implementation Approach

Sampling: Each year, a new cohort will be selected from the eligible enrollment. The survey will be administered as described in the table below. Two years after each cohort receives the survey, they will receive it again, and their baseline compared to the two-year score. The comparison is denoted by the arrowed lines:

[1] SF-36 Physical and Mental Summary Scales: User's Manual, Ware et al pp. 4:3-4:4

Cohort Surveys and Comparisons



Analysis: Two sets of analysis are performed in the calculation of the measure:

- Significance of Change in Status — For each respondent who completed both a baseline and a two-year follow-up survey, the functional health score from the first questionnaire is subtracted from the second score. The difference between mental health scores is classified as "better," "same" or "worse" according to the direction of change and whether the amount is greater or less than expected from chance variation. This will be accomplished by comparing the difference to the 95% confidence interval for an individual scale[2]. The physical health score will also be compared to expected performance; in addition, respondents who died or moved to a long-term facility after completing the first survey will be counted as worse on the physical score.
- Risk Adjustment — The proportions of individuals who are "better," "same" or "worse" will be adjusted using multinomial logistic regression models. These adjusted proportions will be the final reported measures. See the Risk Adjustment Methodology below for more detail regarding these calculations.

Responsibilities of the Plan: The plan will provide its complete eligible enrollment file to an external party each year for sampling. Single-year rates by plan will be reported to HCFA, beginning in 1997, to establish baseline functional status associated with plan. Change scores will first be available in 1999.

Information Reports to Plans: Each year the plan will receive aggregated physical and mental scores, as well as the scales that make up those aggregated scores:

Physical Health

Physical Functioning

Role-Physical

Bodily Pain

General Health

Mental Health

Vitality

Social Functioning

Role-Emotional

Mental Health

[2] SF-36 Physical and Mental Summary Scales: User's Manual, Ware et al pp. p. 5:10

The plan will not receive data on individual responses, for reasons of confidentiality and scientific validity.

Responsibilities of External Parties: All survey administration, data collection and analysis will be done external to the plan.

Notes

- NCQA is sensitive to the additional burden this very important measure places on plans, and is working closely with HCFA to examine possibilities for burden reduction. Plans will be notified by NCQA when details are available.
- To order the SF-36 Health Survey Manual and Interpretation Guide, call the Medical Outcomes Trust at 1 (800)-572-9394.

Risk Adjustment Methodology

Suppose the variables for risk adjustment are x1, x2, etc. Two functions are calculated for each individual:

Lbetter = exp(b0+b1*x1+b2*x2+....)

Lworse = exp(c0+c1*x1+c2*x2+....),

where b0, b1...c0, c1... are coefficients supplied from models developed in the MOS and NHSF studies in the first report and (" * ") represents multiplication. (In subsequent years, the data collected from this effort will be used to refine the model.)

For each individual, the probability of getting better is
Xbetter = Lbetter/(Lbetter+Lworse+1).

The probability of staying the same is
Xsame = 1/(Lbetter+Lworse+1).

The probability of getting worse is
Xworse = Lworse/(Lbetter+Lworse+1).

The percentages better, same and worse observed for equivalent individuals (i.e., risk-adjusted percentages) will be reported, as follows:

Abetter = Xbetter/(Xbetter+Xsame+Xworse)

Asame = Xsame/(Xbetter+Xsame+Xworse)

Aworse = Xworse/(Xbetter+Xsame+Xworse)

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *The expanded mental health diagnosis codes specified in Medicaid HEDIS have been adopted.*
- ➤ *ICD-9-CM code 300.3 has been added.*
- ➤ *The age range has been expanded to include individuals age 6 through 10 years and 65 years and older.*
- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *An exclusionary rule has been added for members who have been discharged directly from the hospital to another inpatient facility (e.g., nursing facility, residential treatment facility).*

Description

The percentage of Medicaid, commercial and Medicare risk members age six years and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled without breaks for 30 days after discharge, and who were seen on an ambulatory basis or were in day/night treatment within 30 days of hospital discharge.

Administrative Data Specification

Calculation: This specification uses either hospital inpatient discharge summaries or the UB-92 to identify those members who have been discharged with a selected mental health diagnosis and uses encounter data (HCFA 1500, UB-92, or equivalent) to identify those who have received appropriate follow-up care. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived by counting discharges for members age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 330 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified below, and who were continuously enrolled without breaks for 30 days after discharge.

Note: This measure is restricted to inpatient hospitalization. Do not count members discharged from residential care or rehabilitation programs.

The following mental health diagnoses are included in this measure:

ICD-9-CM 295.xx	Schizophrenic disorders
ICD-9-CM 296.0x	Manic disorder, single episode
ICD-9-CM 296.1x	Manic disorder, recurrent episode
ICD-9-CM 296.2x	Major depressive disorder, single episode
ICD-9-CM 296.3x	Major depressive disorder, recurrent episode
ICD-9-CM 296.4x	Bipolar affective disorder, manic

ICD-9-CM 296.5x	Bipolar affective disorder, depressed
ICD-9-CM 296.6x	Bipolar affective disorder, mixed
ICD-9-CM 296.7x	Bipolar affective disorder, unspecified
ICD-9-CM 296.8x	Manic-depressive psychosis, other and unspecified
ICD-9-CM 296.9x	Other and unspecified affective psychoses
ICD-9-CM 297.x	Paranoid states
ICD-9-CM 298.x	Other nonorganic psychoses
ICD-9-CM 299.xx	Psychoses with origin specific to childhood
ICD-9-CM 300.3	Obsessive-compulsive disorders
ICD-9-CM 301.x	Personality disorders
ICD-9-CM 308.x	Acute reaction to stress
ICD-9-CM 309.xx	Adjustment reaction
ICD-9-CM 311	Depressive disorder, not otherwise classified
ICD-9-CM 312.xx	Disturbance of conduct, not elsewhere classified
ICD-9-CM 313.xx	Disturbance of emotions specific to childhood and adolescence
ICD-9-CM 314.xx	Hyperkinetic syndrome of childhood

If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the rate. Therefore, a plan should count discharges, not individuals. However, if a discharge for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis within the 30-day follow-up period, only the readmission discharge should be counted. Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.

Numerator: The number of discharges in the denominator for each of the three populations (Medicaid, commercial and Medicare risk) that were followed by an ambulatory mental health encounter or day/night treatment within 30 days of hospital discharge. To identify ambulatory follow-up encounters, use the CPT-4 codes listed below or the UB-92 revenue codes of 901 (psychiatric/psychological treatments, electroshock treatment), 911 (rehabilitation), 912 (psychiatric/psychological services, day care), 913 (psychiatric/psychological services, night care), 914 (individual therapy), 915 (group therapy), 916 (family therapy) or 513 (clinic-psychiatric). The follow-up visit must be with a mental health provider and can be for any mental health diagnosis. Health plans may use Level III HCPCS codes to identify follow-up visits, as long as the codes can be mapped to the service categories represented by the following codes:

CPT-4 codes:

90801	Diagnostic assessment
90820	Interactive interview examination
90841	MD psychotherapy
90842	MD psychotherapy

90843	MD psychotherapy
90844	MD psychotherapy
90845	Medical psychoanalysis
90847	Family psychotherapy
90849	Multifamily group therapy
90853	Group psychotherapy
90855	Individual psychotherapy
90857	Group psychotherapy
90862	Pharmacology management
90870-90871	Electroconvulsive therapy

Hybrid Method Specification

Calculation: This specification uses either hospital inpatient discharge summaries or the UB-92 to identify those members who have been discharged with a selected mental health diagnosis and uses encounter data (HCFA 1500, UB-92, or equivalent) to identify those who have received appropriate follow-up care. Separate calculations are required for the Medicaid, commercial and Medicare risk populations.

Denominator: Three separate denominators, one for each of the three required calculations, are derived using random samples of 411 Medicaid members, 411 commercial members and 411 Medicare risk members from the plan's eligible populations. Using hospital discharge data, identify discharges for Medicaid, commercial and Medicare risk members who were age six years and older at the time of discharge, hospitalized with a discharge date occurring during the first 330 days of the reporting year and a principal ICD-9-CM diagnosis code indicating the mental health disorders specified below, and who were continuously enrolled without breaks for 30 days after discharge.

The following mental health disorder diagnoses are used for this measure:

ICD-9-CM 295.xx	Schizophrenic disorders
ICD-9-CM 296.0x	Manic disorder, single episode
ICD-9-CM 296.1x	Manic disorder, recurrent episode
ICD-9-CM 296.2x	Major depressive disorder, single episode
ICD-9-CM 296.3x	Major depressive disorder, recurrent episode
ICD-9-CM 296.4x	Bipolar affective disorder, manic
ICD-9-CM 296.5x	Bipolar affective disorder, depressed
ICD-9-CM 296.6x	Bipolar affective disorder, mixed
ICD-9-CM 296.7x	Bipolar affective disorder, unspecified
ICD-9-CM 296.8x	Manic-depressive psychosis, other and unspecified
ICD-9-CM 296.9x	Other and unspecified affective psychoses
ICD-9-CM 297.x	Paranoid states

ICD-9-CM 298.x	Other nonorganic psychoses
ICD-9-CM 299.xx	Psychoses with origin specific to childhood
ICD-9-CM 300.3	Obsessive-compulsive disorders
ICD-9-CM 301.x	Personality disorders
ICD-9-CM 308.x	Acute reaction to stress
ICD-9-CM 309.xx	Adjustment reaction
ICD-9-CM 311	Depressive disorder, not otherwise classified
ICD-9-CM 312.xx	Disturbance of conduct, not elsewhere classified
ICD-9-CM 313.xx	Disturbance of emotions specific to childhood and adolescence
ICD-9-CM 314.xx	Hyperkinetic syndrome of childhood

If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the sampling frame. However, if a discharge for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis within the 30-day follow-up period, only the readmission discharge should be counted. Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.

Numerator: The number of discharges in the denominator for each of the three populations (Medicaid, commercial, and Medicare risk) for which there is documentation of an ambulatory mental health encounter or day/night treatment within 30 days of discharge, as documented through either administrative data or medical record review. The follow-up visit must be with a mental health provider and can be for any mental health diagnosis.

Notes

- If a Medicaid, commercial or Medicare risk member identified in the denominator of this measure is rehospitalized for a non-mental health, non-chemical dependency diagnosis within 30 days of discharge for one of the selected mental health disorder hospitalizations, that member should be dropped from this measure, because the rehospitalization may prevent an ambulatory follow-up visit from taking place.
- Plans may exclude from the denominator those individuals who have been discharged directly from the hospital to a non-acute setting (e.g., nursing facility, residential treatment facility). This is a change from HEDIS 2.5 and Medicaid HEDIS in an effort to produce more accurate rates.
- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.

FREQUENCY OF ONGOING PRENATAL CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain. It remains applicable only to the Medicaid population.*

Note: This measure is significant and relevant to both Medicaid and commercial enrollees. However, because this measure has been newly developed for Medicaid HEDIS and not yet implemented, the CPM agreed that it should continue to be required for Medicaid enrollees, and be evaluated for the commercial population. By implementing this measure in state Medicaid programs, valuable information will be available to help assess the measure's applicability to a broader population.

Description

The percentage of pregnant Medicaid-enrolled women who received < 21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the expected number of prenatal care visits, adjusted for gestational age and the month prenatal care began.

Administrative Data Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of live deliveries to enrolled women during the reporting year. Hospital discharge data, hospital records, birth certificates, or claims/encounter data are used to compare the number of prenatal care visits a woman received while in the plan to the expected number of visits, adjusted for the month prenatal care began and gestational age.

For each woman who had (a) live birth(s) during the reporting year, the plan will: 1) identify the actual number of prenatal care visits, 2) identify the number of expected visits, 3) calculate the ratio of received-to-expected visits, and 4) report an unduplicated count of the number of women who had <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began in the plan and gestational age. Plans will report five rates.

Denominator: All Medicaid enrolled women who delivered (a) live birth(s) during the reporting year.

Note: To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone, while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed to document live births, the plan is responsible for verifying that only live births are included in this measure.

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of women in the denominator who had an unduplicated count of <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age. Use the following steps to calculate each woman's ratio of observed-to-expected prenatal care visits.

For each woman included in the denominator:

- Identify date of delivery, using hospital discharge data.
- Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries or labor and delivery records) or birth certificate. Gestational age is defined as the number of completed weeks that have elapsed between the first day of the last normal menstrual period and the date of delivery. Methods recommended to determine gestational age are: 1) physician ascertainment using ultrasound or Dubowits assessment, and 2) last menstrual period (LMP) calculation (Date of LMP – Date of delivery ÷ 7). If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

- ➤ Identify the date on which prenatal care began while enrolled in the plan, using encounter data.
- ➤ Using gestational age (from Step 2), determine the number of ACOG-recommended visits a woman should have received from the time prenatal care was initiated (refer to Table 5A). ACOG recommends that women with an uncomplicated pregnancy receive visits every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter.
- ➤ Using Table 5A, adjust the number of expected ACOG prenatal visits by gestational age and the month prenatal care began during enrollment in the plan. The chart subtracts the number of missed visits prior to the date prenatal care began (Step 3) from the number of recommended visits for a given gestational age. For example, ACOG recommends 14 visits for a 40-week gestation. If care began in month four (three missed visits during enrollment in the plan), the expected number of visits is 14 – 3 = 11.
- ➤ Identify the number of prenatal care visits the member received during the course of her pregnancy and enrollment in the health plan using ambulatory/encounter data.

Note: *We recommend that plans use Table 1E in the Prenatal Care in the First Trimester measure as the basis of their search to identify prenatal care visits. Plans may use any of the four rules presented in that table to search for evidence of prenatal care; a woman's record need satisfy only one of the rules. In addition to the other codes listed in the table, plans may also use CPT-4 code 76810 in Decision Rules 2 and 3. Plans should document their method for identifying prenatal care, whether or not these decision rules were followed.*

- ➤ Calculate the ratio of observed visits (Step 6) over expected visits (Step 5).
- ➤ Report each woman in the appropriate category: <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits. Plans should report five numerators.

Hybrid Method Specification

Calculation: This specification uses hospital discharge and membership data to identify the number of live deliveries to enrolled women during the reporting year. Hospital discharge data, hospital records, birth certificates, or claims/encounter data and/or medical record review are used to compare the number of prenatal care visits a woman received while in the plan to the expected number of visits, adjusted for the month prenatal care began in the plan and gestational age.

Denominator: A random sample of 411 Medicaid members drawn from the plan's eligible population. Eligible members include Medicaid enrolled women who delivered (a) live birth(s) during the reporting year.

Note: *To ensure the completeness and validity of live-birth information, plans often use several data sources with different coding schemes. Codes are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone, while others may be used as part of a combination of codes (e.g., V codes may be used alone; CPT-4 procedure codes may be used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed to document live births, the plan is responsible for verifying that only live births are included in this measure.*

To identify deliveries resulting in live births, women who have been discharged with one of the following codes should be counted:

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Numerator: The number of enrolled women in the sample who had an unduplicated count of <21%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began while enrolled in the plan and gestational age. The visit may be identified through either administrative data or medical record review. Use the steps provided in the administrative data specifications above to adjust the number of expected prenatal visits for the month prenatal care began while enrolled in the plan and gestational age. For (a) prenatal care visit(s) to a midwife or OB provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing and/or echography of a pregnant uterus.

OR

Evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of last menstrual period (LMP) or estimated date of confinement (EDC).

OR

Documentation of LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

For (a) prenatal care visit(s) to a family practitioner or other primary care provider, documentation in the medical record must include an author-identified note indicating the date on which the prenatal care visit(s) occurred and evidence of one of the following:

A basic physical obstetrical examination that includes either auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used).

OR

Evidence that a prenatal care procedure was performed, such as screening test in the form of either an obstetrical panel, or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, and/or echography of a pregnant uterus and evidence that a diagnosis of pregnancy has been established, in the form of a complete medical and obstetrical history and documentation of last menstrual period (LMP) or estimated date of confinement (EDC).

OR

Evidence that a prenatal care procedure was performed, such as a screening test in the form of either an obstetric panel, a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, an antenatal screen, and/or echography of a pregnant uterus and evidence that a diagnosis of pregnancy has been established in the form of a documented LMP or EDC in conjunction with either prenatal risk assessment and counseling/education or a complete obstetrical history.

Note that the numerator is calculated retroactively from time of delivery or estimated date of confinement.

Notes

- For a prenatal care visit to a family practitioner or other primary care provider, documentation in the medical record at the time of the prenatal care visit need not include a complete medical history if the primary care provider is the patient's regular doctor and has documented the patient's medical history elsewhere in the medical record.
- By specifying the population at risk to include only live births, this measure captures only a percentage of a plan's Medicaid members' pregnancies.
- Women who delivered in a birthing center should be included in this measure.
- When counting prenatal visits, include visits to physicians, nurse practitioners and midwives, as well as registered nurses provided that evidence of co-signature by a physician is present, if required by state law.
- This measure does not have a continuous enrollment criterion, since pregnancy is a criterion for Medicaid eligibility; it is very unlikely that a woman enrolled during pregnancy would disenroll and re-enroll during this period.

Table 5A: Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Prenatal Care Began

	Gestational Age in Weeks																
Month prenatal care began	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**
9th month	-	-	-	-	-	-	-	-	-	-	-	1	1	2	3	4	5
8th month	-	-	-	-	-	-	1	1	1	2	3	4	5	6	7	8	9
7th month	-	-	1	1	1	1	2	2	3	4	5	6	7	8	9	10	11
6th month	1	1	1	1	2	2	3	3	4	5	6	7	8	9	10	11	12
5th month	1	1	2	2	3	3	4	4	5	6	7	8	9	10	11	12	13
4th month	3	3	4	4	5	5	6	6	7	8	9	10	11	12	13	14	15
3rd month	4	4	5	5	6	6	7	7	8	9	10	11	12	13	14	15	16
2nd month	5	5	6	6	7	7	8	8	9	10	11	12	13	14	15	16	17
1st month	6	6	7	7	8	8	9	9	10	11	12	13	14	15	16	17	18

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain and now applies to the commercial population as well.*

Description

The percentage of Medicaid and commercially enrolled members who turned 15 months old during the reporting year, who were continuously enrolled in the plan from 31 days of age, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify members who have turned 15 months old during the reporting year. Claims/encounter data are used to identify those members who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Health plans will calculate seven rates for each of the two populations (Medicaid and commercial). A child should be included in only one numerator (e.g., a child receiving six well-child visits will not be included in the rate for five, four or fewer well-child visits).

Denominator: For each population (i.e., Medicaid and commercial), the denominators are the same for all seven rates: All members who turned age 15 months during the reporting year, who were members of the plan as of the day they turned age 15 months and who were continuously enrolled in the health plan from 31 days of age. Members who have had no more than one break in enrollment of up to 45 days should be included in this measure.

Note: *Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month deadline as the child's first birthday plus 90 days. For example, if a child, born on January 9, 1995, is included in the rate of six or more well-child visits, he or she must have had six well-child visits by April 9, 1996.*

Numerator: For each population (i.e., Medicaid and commercial), seven separate numerators are calculated, corresponding to the number of members in the denominator who received either zero, one, two, three, four, five, or six or more well-child visits with

a primary care provider during their first 15 months of life. A child is considered to have received a well-child visit if he or she had a claim/encounter that meets one of the following criteria:

CPT-4 codes:
Preventive medicine services

99381	New patient under one year
99382	New patient (ages 1-4 years)
99391	Established patient under one year
99392	Established patient (ages 1-4 years)
99431	Newborn care (history and examination)
99432	Normal newborn care

OR

ICD-9-CM codes:

V20-V20.2	Health supervision of infant and child
V70.0	General medical examination (routine)
V70.3-V70.9	General medical examination

Note: *The above CPT-4 and ICD-9-CM codes may be used alone or with other codes.*

OR

CPT-4 codes:
Evaluation and management codes

99201-99205	New patient
99211-99215	Established patient

Note: *These CPT-4 codes must be used in conjunction with V codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.*

Hybrid Method Specification

Calculation: This specification uses membership data to identify members who turned 15 months old during the reporting year. Claims/encounter data and/or medical record review are used to identify those members who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Health plans will calculate seven rates for each of the two populations separately (Medicaid and commercial). A child should be included in only one numerator (e.g., a child receiving six well-child visits will not be included in the rate for five, four or fewer well-child visits).

Denominator: For each population (i.e., Medicaid and commercial), the denominators are the same for all seven rates: A random sample of 411 Medicaid members and 411 commercial members drawn from the health plan's eligible populations. Eligible members include Medicaid and commercial members who turned age 15 months during the reporting year, who were members of the plan as of the day they turned age 15 months, and who were continuously enrolled from 31 days of life. Members who have had no more than one break in enrollment of up to 45 days should be included in this measure.

Note: *Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month deadline as the child's first birthday plus 90 days. For example, if a child, born on January 9, 1995, is included in the rate of six or more well-child visits, he or she must have had six well-child visits by April 9, 1996.*

Numerator: For each population (i.e., Medicaid and commercial), seven separate numerators are calculated, corresponding to the number of enrolled members in the sample who received either zero, one, two, three, four, five or six or more well-child visits with a primary care provider during their first 15 months of life, as documented through either administrative data or medical record review. Documentation in the medical record must include an author-identified note indicating the date on which the well-child visit occurred and, at a minimum, evidence of the following: a health and developmental history, both physical and mental; a physical exam; and health education/anticipatory guidance.

Notes

- For health plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-child visits only.
- Plans with internal codes or other transaction data not cited above for Medicaid members, that denote an EPSDT well-child visit, may use these codes as long as they document methods used to track EPSDT well-child visits.
- Some states that have specific EPSDT codes for Medicaid beneficiaries may require plans to apply these codes when using administrative data specifications.
- The CPM realizes that preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted, regardless of the primary intent of the visit.

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEAR OF LIFE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain and now applies to the commercial population as well.*
- ➤ *The age range has been expanded to include three-year olds, conforming with the American Academy of Pediatrics Periodicity Schedule.*

Description

The percentage of Medicaid and commercially enrolled members who were three, four, five or six years old during the reporting year, who were continuously enrolled during the reporting year, and who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year are included in this measure.

Administrative Data Specification

Calculation: This specification uses membership data to identify members who are three, four, five or six years old during the reporting year. Claims/encounter data are used to identify those members who received one or more well-child visit(s) with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the two required calculations, are derived using all members who were three, four, five or six years old as of December 31 of the reporting year and who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year are included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who received at least one well-child visit with a primary care provider during the reporting year. A child is considered to have received a well-child visit if he/she had a claim/encounter with a primary care provider that meets one of the following criteria:

CPT-4 codes:
Preventive medicine services

99382	New patient (ages 1 through 4 years)
99383	New patient (ages 5 through 11 years)
99392	Established patient (ages 1 through 4 years)
99393	Established patient (ages 5 through 11 years)

OR

ICD-9-CM codes:

V20-V20.2	Health supervision of infant and child
V70.0	General medical examination (routine)
V70.3-V70.9	General medical examination

Note: The CPT-4 and ICD-9-CM codes above may be used alone or with other codes.

OR

CPT-4 codes:
Evaluation and management codes

99201-99205	New patient
99211-99215	Established patient

Note: These CPT-4 codes must be used in conjunction with V codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

Hybrid Method Specification

Calculation: This specification uses membership data to identify members who were three, four, five or six years old. Claims/encounter data and/or medical record review are used to identify those members who have had one or more well-child visit with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the required calculations, are derived from a random sample of 411 Medicaid members and 411 commercial members drawn from the plan's eligible populations. Eligible members are those members who were three, four, five or six years old as of December 31 of the reporting year, who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year are included in this measure.

Numerator: The number of enrolled members in the denominator for each of the two populations (Medicaid and commercial) who have had at least one well-child visit with a primary care provider during the reporting year, as documented through either administrative data or medical record review. Documentation in the medical record must include an author-identified note indicating the date on which the well-child visit occurred and, at a minimum, evidence of the following: a health and developmental history, both physical and mental; a physical exam; and health education/anticipatory guidance.

Notes

- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for health plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-child visits only.
- Plans that use internal codes or other transaction data not cited above to denote an EPSDT well-child visit may use these codes, as long as the method used to track EPSDT well-child visits is documented.
- Some states that have specific EPSDT codes may require plans to apply these codes when using administrative data specifications.
- Visits to school-based clinics may be counted if documentation of a well-child exam is available in the medical record or administrative system before December 31 of the reporting year (i.e., entries made retroactive to the reporting year are not counted).
- The CPM recognizes that preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted, regardless of the primary intent of the visit.

ADOLESCENT WELL-CARE VISITS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

➤ *This measure, from the Quality of Care section in Medicaid HEDIS, has been moved to the Use of Services domain and now applies to the commercial population as well.*

Description

The percentage of Medicaid and commercially enrolled members who were age 12 through 21 years during the reporting year who were continuously enrolled during the reporting year and who have had at least one comprehensive well-care visit with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Administrative Data Specification

Calculation: This measure uses membership data to identify members who were age 12 through 21 years during the reporting year. Claims/encounter data are used to identify those members who received one or more comprehensive well-care visits with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the required calculations, are derived using all members age 12 through 21 years as of December 31 of the reporting year who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of members in the denominator for each of the two populations (Medicaid and commercial) who have had at least one comprehensive well-care visit with a primary care provider during the reporting year. An adolescent is considered to have received a comprehensive well-care visit if he or she had a claim/encounter that meets one of the following criteria:

CPT-4 codes:
Preventive medicine services

99383	New patient (5 through 11 years)
99384	New patient (12 through 17 years)
99385	New patient (18 through 39 years)
99393	Established patient (5 through 11 years)
99394	Established patient (12 through 17 years)
99395	Established patient (18 through 39 years)

OR

ICD-9-CM codes

V20-V20.2	Health supervision of infant and child
V70.0	General medical examination (routine)
V70.3-V70.9	General medical examination

Note: The above CPT-4 and ICD-9-CM codes may be used alone or with other codes.

OR

CPT-4 codes:
Evaluation and management codes

99201-99205	New patient
99211-99215	Established patient

Note: These CPT-4 codes must be used in conjunction with V codes V20-20.2, V70.0 and V70.3-70.9.

Hybrid Method Specification

Calculation: This specification uses membership data to identify members who were age 12 through 21 years during the reporting year. Claims/encounter data and/or medical record review are used to identify those members who have had at least one comprehensive well-care visit with a primary care provider during the reporting year. Separate calculations are required for the Medicaid and commercial populations.

Primary care providers are defined as health care practitioners whom members are able to select as primary care providers as their first point of entry into the system and who are defined by the plan as primary care providers for that purpose.

Denominator: Two separate denominators, one for each of the required calculations, are derived from random samples of 411 Medicaid members and 411 commercial members drawn from the plan's eligible populations. Eligible members include Medicaid and commercial members who were age 12 through 21 years as of December 31 of the reporting year who were continuously enrolled during the reporting year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.

Numerator: The number of enrolled members in the denominator for each of the two populations (Medicaid and commercial) who received at least one comprehensive well care visit with a primary care provider during the reporting year, as documented through either administrative data or medical record review. Documentation in the medical record must include an author-identified note indicating the date on which the well-care visit occurred and, at a minimum, evidence of the following: a health and developmental history, both physical and mental; a physical exam, and health education/anticipatory guidance.

Notes

- For plans that offer a Medicaid product and apply a full-month eligibility criterion to its beneficiaries and for health plans that verify enrollment in monthly intervals (i.e., in increments of one month) on their information systems, a 45-day break in enrollment is the equivalent of a 30-day or one-month eligibility period.
- Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted in this measure. The intent is to capture comprehensive well-care visits only.
- Plans with internal codes, or other transaction data not cited above for Medicaid members, that denote an EPSDT well-child visit may use these codes as long as the method used to track EPSDT well-child visits is documented.
- Some states that have specific EPSDT codes for Medicaid beneficiaries may require plans to apply these codes when using administrative data specifications.
- Visits to school-based clinics may be counted if documentation that a well-child exam occurred is available in the medical record or administrative system before December 31 of the reporting year (i.e., entries made retroactive to the reporting year are not counted).
- The CPM recognizes that preventive services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted, regardless of the primary intent of the visit.

FORMULAS AND INSTRUCTIONS FOR USE OF SERVICES MEASURES

The following formulas are used throughout the remaining part of the Use of Services domain. Where indicated, these formulas should be adjusted for age and sex stratification.

Note: These formulas are adapted from the Minnesota Utilization Data Definitions Committee's Reporting Standards for Health Care Utilization Data, February, 1992.

Age of Members

Unless otherwise specified, report member age as of the date of service. If the service is an inpatient admission, use age as of the date of discharge.

Average Length of Stay

Total days/total discharges.

Discharges

Total discharges associated with (a) particular diagnosis code(s).

Member Months

The sum of the enrollment in the health plan for each month during the reporting year (i.e., the sum of the 12 monthly membership totals).

See also the Health Plan Descriptive Information domain for instructions on the calculation of member months.

Member Years

Member years serve as a proxy for annual membership and are calculated as:

X member months/12 months = Y member years.

Discharges per 1,000 Member Months

(Total discharges/member months) x 1,000

Discharges per 1,000 Members per Year

(Total discharges/member months) x 1,000 x 12

Discharges per 1,000 Female Member Months, stratified

For all tables in this chapter that are stratified by age (or by age and sex), rate per 1,000 member months means:

Member months within the particular age and sex category specified in each row of the table e.g., [(total discharges for female members age 20 through 34 years) ÷ (member months of female members age 20 through 34 years)] x 1,000

Discharges per 1,000 Female Members per year, stratified

For all tables in this chapter that are stratified by age (or by age and sex), rate per 1,000 members per year means:

Members within the particular age and sex category specified in each row of the table e.g., [(total discharges for female members age 20 through 34 years) ÷ (member months of female members age 20 through 34 years)] x 1,000 x 12

Length of Stay (LOS)

If all days are approved, the LOS is the number of days from admission to discharge; the last day of the stay is not counted, unless the admission and discharge date are the same.

LOS = Discharge date – Admit date

If some of the days are denied, the length of stay is the number of days from admit to discharge, not counting the last day of the stay, less the number of denied days:

LOS = Discharge date – Admit date – Denied days.

Note: *When an inpatient revenue code (a UB-92 or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admit date are the same, then the discharge date minus admit date equals one day, not zero. Adjust the LOS accordingly.*

Total Days Incurred

The sum of the length of stay for all discharges during a reporting year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days. Total days include days that occur before January 1 of the reporting year for discharge dates occurring during the reporting year.

Total Days Incurred = sum of LOS for each discharge during the reporting year.

Total Days Incurred per 1,000 Members per Year

(Total days incurred/member months) x 1,000 x 12.

Notes

- A table reporting member months per age category (and sex category, if required) is provided with each Use of Services table. Member months per each category is used as the denominator to calculate use of services rates reported in each table.
- Continuous enrollment requirements apply to the following measures:

  Readmission for Specified Mental Health Disorders (Table 5L) and Readmission for Chemical Dependency (Table 5O).
- For all measures in which the specifications offer plans the option of using a DRG, the use of DRG codes is preferred. If DRGs are unavailable, plans should use the other specified methods (e.g., ICD-9-CM codes).
- The following measures were originally adopted from the Minnesota Utilization Data Definitions Committee's Standards for Health Care Utilization Data; February 1992: Inpatient Utilization — General Hospital/Acute Care; Ambulatory Care; Discharge and Average Length of Stay — Maternity Care; Cesarean Section Rate and Vaginal Birth after Cesarean Section Rate (VBAC-Rate); Mental Health Utilization — Inpatient Discharges and Average Length of Stay; Mental Health Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services; Readmission for Selected Mental Health Disorders; Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay; Chemical Dependency Utilization — Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services; Readmission for Chemical Dependency.

Stratification by Payer/Eligibility Category

Members enrolled in a health plan who are covered by different payers tend to vary considerably by sociodemographic characteristics, average time of enrollment and utilization patterns. For this reason, Use of Services tables will be reported separately for each payer (i.e., Medicaid, commercial and Medicare risk). For Medicaid members only, the Use of Services tables should be reported by eligibility category.

Throughout the Use of Services domain, tables are designated as follows:

Table 1a	Total Medicaid
Table 1b	Medicaid/Medicare Dual Eligibles
Table 1c	Medicaid — Disabled
Table 1d	Medicaid — Other Low Income
Table 2a	Commercially Enrolled — Health Plan Wide (for each product type)
Table 2b	Commercially Enrolled — Employer/Purchaser Specific
Table 3	Medicare Risk

Medicaid enrollees: Refer to the Health Plan Descriptive Information domain for a definition of the Medicaid eligibility categories. Note that Medicaid enrollees in Category 1 (limited benefit package) are not reported separately, but included in Table 1a (Total Medicaid). The sum of Table 1b (Dual Eligibles), 1c (Disabled) and 1d (Other Low Income), therefore, does not equal Table 1a (Total Medicaid).

Information on the categorization of Medicaid enrollees is to be provided to the health plan by the state. If a state does not provide this data, the health plan may report "Total Medicaid" only.

Dual eligibles should be reported in Table 1a (Total Medicaid) and Table 1b (Medicaid/Medicare Dual Eligibles) regardless of the kind of Medicare coverage. Dual eligibles should be reported in Table 3 (Medicare Risk) if the health plan holds a Medicare risk contract. Medicaid/Medicare risk dual eligibles will, therefore, be counted both under Medicaid and Medicare.

Commercial enrollees: Both "direct pay" and "group" enrollees should be reported as commercial enrollees. Table 2a (Health Plan Wide — for each product type) reports on all of the plan's commercial enrollees. Table 2b (Employer/Purchaser Specific) reports only on the enrollees covered by a particular employer or purchaser.

Because utilization patterns vary with population characteristics, there is no "total" Use of Services table summarizing information on all enrolled health plan members.

Use of Services tables will have up to seven versions (i.e., 1a, 1b, 1c, 1d, 2a, 2b and 3). Complete only the tables relevant to the plan (i.e., tables reflecting the populations for whom the plan serves).

Use of Services data should be reported on the basis of **member years** for commercial and Medicare risk members and on the basis of **member months** for Medicaid members (this acknowledges that Medicaid beneficiary enrollment in managed care tends to be less stable than enrollment of commercial or Medicare members).

Unless otherwise specified, a plan member should be assigned to a category based on his/her payer and, for Medicaid members, on type of eligibility on the date of service.

If the service is an inpatient admission, use the payer/type of eligibility category as of the member's discharge date.

For individuals who are enrolled in more than one payer group during the reporting year, count the number of months attributable to each payer in the respective table.

Report age as of the date of service for the Use of Services measures. For inpatient admissions, report age as of the date of discharge.

Stratification by Age

Because of the demographic characteristics of the Medicaid and Medicare risk populations, most Use of Services tables have more detailed age categories, especially for children and for members age 65 years or older.

For Commercial Reporting: When a Use of Services table requests a non-percentage rate (e.g., discharges per 1,000 members) and a plan's total enrollment for the table is less than 1,000, the plan should not report the table. This applies to both plan-wide and employer-specific reporting. If the enrollment in a particular age/sex category is less than 30, plans should suppress the reporting (i.e., leave the cell blank) for that category. The same recommendation applies if a Use of Services table requests a percentage, and a plan's enrollment in a particular age/sex category (i.e., the denominator) is less than 30. When tables contain fewer than 30 members for a particular age and/or sex category, health plans should report only the "Total" or "Grand Total" for the indicator. (For example, a health plan reporting mental health inpatient discharges for an

employer group finds that of the 34 males receiving inpatient mental health services, 14 are between 13-17 years of age and 20 are between 18-64 years of age. In the employer specific table, the plan should report only that 34 Total Males received inpatient mental health services.)

For Medicaid and Medicare Risk Reporting: When reporting Use of Services tables for the Medicaid and Medicare Risk populations, if the enrollment in a particular age/sex category is less than 30, plans should report the number (numerator) of events of interest (e.g., newborns, discharges, surgeries/procedures, days) but not calculate the requested rate.

If a Use of Services table requests a percentage and a plan's enrollment in a particular age/sex category (i.e., the denominator) is less than 30 plans should report the number (numerator) of events of interest, but not calculate the percentage.

Calculating rates based on numbers below these thresholds is not advisable, and small numbers should not be used for plan-to-plan comparison. States and HCFA will (if they desire) be able to calculate rates for Medicaid and Medicare members using the numerator data in conjunction with member months in each age/sex category provided with each utilization table. This allows states and HCFA to aggregate these data with those of other managed care plans to produce statewide or national data.

FREQUENCY OF SELECTED PROCEDURES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *For commercial members, three procedures have been added.*
- ➤ *Coding has been updated.*

Description

This measure provides a summary of the number and rate of several frequently performed procedures. These procedures often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Specifications

Calculation: This measure should be reported separately by payer (i.e., Medicaid, commercial and Medicare risk). For Medicaid members, report the absolute number of procedures and the number of procedures per 1,000 Member Months. For commercial and Medicare risk members, report the absolute number of procedures and the number of procedures per 1,000 Members per Year.

Note: *If, for the same procedure, two or more codes appear on the same date of service for the same patient, the procedure should count once (e.g., CPT-4 code 47610 and CPT-4 code 47620 on July 10, 199X, on the same patient would count once toward the number of cholecystectomies; ICD-9-CM code 60.21 and CPT-4 code 52630 on May 3, 199X, on the same patient would count once toward the number of prostatectomies.)*

Medicaid: Table 5C-1a reports the total number of procedures and the rate of procedures per 1,000 Member Months, by age and sex.

Note: *This measure is reported only for Total Medicaid. Reporting this information by Medicaid eligibility category would result in small numbers.*

Commercial: Tables 5C-2a and 5C-2b are constructed using Table 5C-2 as a template. Report the total number of procedures and the rate of procedures per 1,000 Members per Year for the appropriate age and sex categories.

Medicare: Table 5C-3 reports the total number of procedures and the rate of procedures per 1,000 Members per Year for Medicare risk members.

Table 5B: Codes

These classification codes are used to identify the procedures reported in Tables 5C-1a, 5C-2a-b, 5C-3

Procedure	ICD-9-CM Procedure Codes	CPT-4 Codes
Myringotomy: (Myringotomy or Myringotomy with Adenoidectomy) *Medicaid and Commercial* Males, Females, Age 0-4 Males, Females, Age 5-19	20.01	69433, 69436
Tonsillectomy: (Tonsillectomy or Tonsillectomy with Adenoidectomy) *Medicaid and Commercial* Males, Females, Age 0-9 Males, Females, Age 10-19	28.2, 28.3, 28.4	42820, 42821, 42825, 42826, 42860
Non-Obstetric Dilation and Curettage: *Medicaid and Commercial* Females, Age 15-44 Females, Age 45-64	69.09	58120
Hysterectomy: *Medicaid and Commercial* Females, Age 15-44 Females, Age 45-64 *Medicare risk* Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	68.3, 68.4, 68.5, 68.51, 68.59, 68.6, 68.7, 68.8, 68.9	56308, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58951, 59135, 59525
Cholecystectomy: open and closed (laparoscopic) cholecystectomy reported separately *Medicaid and Commercial* Males, Age 30-64 Females, Age 15-44 Females, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	**open:** 51.21, 51.22 **closed (laparoscopic):** 51.23, 51.24	**open:** 47600, 47605, 47610, 47612, 47620 **closed (laparoscopic):** 56340, 56341, 56342
Laminectomy/Diskectomy: *Commercial* Male, Age 20-64 Female, Age 20-64	03.02, 03.09, 80.50, 80.51, 80.59	22220, 22222, 22224, 22226, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091
Angioplasty (PTCA): *Commercial* Males, Age 45-64 Females, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	36.01, 36.02, 36.05	92982, 92995, 92980, 92981, 92984, 92996
Cardiac Catheterization: *Commercial* Males, Age 45-64 Females, Age 45-64	37.21-37.23, 88.55, 88.56, 88.57	93501, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93539, 93540, 93543, 93544, 93545, 93541, 93542

Table 5B: Continued

Procedure	ICD-9-CM Procedure Codes	CPT-4 Codes
Coronary Artery Bypass Graft: *Commercial* Males, Age 45-64 Females, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17, 36.19, 36.2	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33572
Prostatectomy: *Commercial* Males, Age 45-64 *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+	60.21, 60.29, 60.3, 60.4, 60.5, 60.61, 60.62, 60.69	52601, 52612, 52614, 52620, 52630, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 52647, 52648
Reduction of Fracture of Femur: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	79.05, 79.15, 79.25, 79.35	27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248
Total Hip Replacement: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	81.51	27130, 27132, 27134
Total Knee Replacement: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	81.54	27446, 27447
Partial Excision of Large Intestine: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	45.7x	44140, 44141, 44143, 44144, 44145, 44146, 44147
Carotid Endarterectomy: *Medicare risk* Males, Age <65 Males, Age 65-74 Males, Age 75-84 Males, Age 85+ Females, Age <65 Females, Age 65-74 Females, Age 75-84 Females, Age 85+	38.12	34001, 35001, 35301, 35501, 35601, 35390

Notes

➤ Procedures can be identified using either the specified ICD-9-CM or CPT-4 codes. Health plans should report counts for the procedures as specified. All procedures should be included in the count regardless of the site of care. For example, include myringotomies performed in ambulatory and inpatient settings. The total number of procedures should be reported rather than the number of members who received the procedure.

Myringotomy:

- The measure intends to measure the frequency of "Myringotomy with tube replacement".
- This measure includes Myringotomies or Myringotomies and Adenoidectomies. Adenoidectomies performed alone do not count towards this measure.
- ICD-9-CM code 20.09 and CPT-4 codes 69420 and 69421 do not count towards this measure.
- Myringotomy and Tonsillectomy occurring on the same date of service count toward both measures.

Tonsillectomy:

- Tonsillectomy or Tonsillectomy and Adenoidectomy count towards this measure; Adenoidectomy performed alone does not count towards this measure.
- Myringotomy and Tonsillectomy occurring on the same date of service count toward both measures.

Non-Obstetric Dilation and Curettage:

- This category does not include obstetric D&C or termination of pregnancy D&C.
- ICD-9-CM codes 69.01 and 69.02 and CPT-4 code 57820 do not count toward this measure.
- A non-obstetric D&C performed in conjunction with (i.e., on the same date of service as) a hysterectomy should not be counted in the D&C rate; count only the hysterectomy.

Cholecystectomy:

- Report open and closed (laparoscopic) cholecystectomy separately.

Laminectomy/Diskectomy:

- This measure is intended to capture disk surgeries. For this reason, CPT-4 codes relating to laminectomies without disk removal are excluded.

Cardiac Catheterization:

- A cardiac catheterization performed in conjunction with (i.e., on the same date of service as) an angioplasty should not be counted in the cardiac catheterization rate; count only the angioplasty.

CABG:

- Regardless of the number of arteries involved or the number or types of grafts involved, count each CABG procedure only once for each date of service per patient.

Carotid Endarterectomy:

- CPT-4 code 35002 does not count toward the measure; it does not relate to an elective procedure.

➤ For Medicaid members, dilation and curettage procedures and tonsillectomy procedures with or without adenoidectomy (excludes isolated adenoidectomies) were included because geographic variation in the frequency of their performance was found. Myringotomy with or without adenoidectomy (excludes isolated adenoidectomies) was also added because this procedure addresses otitis media, a condition very common in children.

Table 5C-1a: Frequency of Selected Procedures: Medicaid

Age	Member Months		
	Male	Female	Total
0-4			
0-9			
5-19			
10-19			
15-44			
30-64			
45-64			

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Member Months
Myringotomy	0-4	Male and Female		
	5-19	Male and Female		
Tonsillectomy Adenoidectomy	0-9	Male and Female		
	10-19	Male and Female		
Dilation & Curettage	15-44	Female		
	45-64	Female		
Hysterectomy	15-44	Female		
	45-64	Female		
Cholecystectomy, open	30-64	Male		
	15-44	Female		
	45-64	Female		
Cholecystectomy, closed (laparoscopic)	30-64	Male		
	15-44	Female		
	45-64	Female		

Template Table 5C-2: Frequency of Selected Procedures: Commercial

Age	Member Months: Male	Female	Total
0-4			
0-9			
5-19			
10-19			
15-44			
20-64			
30-64			
45-64			

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
Myringotomy	0-4	Male and Female		
	5-19	Male and Female		
Tonsillectomy Adenoidectomy	0-9	Male and Female		
	10-19	Male and Female		
Dilation & Curettage	15-44	Female		
	45-64	Female		
Hysterectomy	15-44	Female		
	45-64	Female		
Cholecystectomy, open	30-64	Male		
	15-44	Female		
	45-64	Female		
Cholecystectomy, closed (laparoscopic)	30-64	Male		
	15-44	Female		
	45-64	Female		
Laminectomy Diskectomy	20-64	Male		
	20-64	Female		
Angioplasty (PTCA)	45-64	Male		
	45-64	Female		
Cardiac Catheterization	45-64	Male		
	45-64	Female		
CABG	45-64	Male		
	45-64	Female		
Prostatectomy	45-64	Male		

Table 5C-3: Frequency of Selected Procedures: Medicare Risk

	Member Months		
Age	**Male**	**Female**	**Total**
< 65			
65-74			
75-84			
85+			

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
CABG	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Angioplasty (PTCA)	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Carotid Endarterectomy	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		

Table 5C-3: Continued

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
Reduction of Fracture of Femur	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total Hip Replacement	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total Knee Replacement	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Partial Excision of Large Intestine	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		

Table 5C-3: Continued

Procedure	Age	Sex	Number of Procedures	Procedures/1,000 Members
Cholectystectomy, Open	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Cholecystectomy, Closed (laparoscopic)	< 65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Hysterectomy	< 65	Female		
	65-74	Female		
	75-84	Female		
	85+	Female		
Prostatectomy	< 65	Male		
	65-74	Male		
	75-84	Male		
	85+	Male		

INPATIENT UTILIZATION — GENERAL HOSPITAL/ACUTE CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *Age stratification is more detailed for children and for members age 65 years and older, to account for demographic characteristics of the Medicaid and Medicare populations.*
- *Newborns are no longer reported in this measure; however, the Births and Average Length of Stay, Newborns measure was modified so that newborn utilization rates can be added to utilization rates reported in this measure.*
- *Medical and surgical services are reported separately.*
- *In addition to reporting Days and Discharges, health plans are asked to report Discharges/1,000 Member Months and Days/1,000 Member Months for Medicaid members, and Discharges/1,000 Members per Year and Days/1,000 Members per Year for commercial and Medicare risk members.*

Description

This table summarizes utilization of acute inpatient services in the following categories: total services, medicine, surgery and maternity. Nonacute care, mental health and chemical dependency services, as well as newborns, are excluded.

Specifications

Calculation:

Medicaid: Tables 5D-1a, 5D-1b, 5D-1c and 5D-1d are constructed using Table 5D-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days, Days/1,000 Member Months and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: 5D-2a, 5D-2b and 5D-3 are constructed using Table 5D-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days, Days/1,000 Members per Year and Average Length of Stay for the members in the payer group that each table addresses.

Total general hospital/acute care services should exclude mental health and chemical dependency, as well as newborns, all of which are reported separately. Gynecology and pediatric care should be reflected in the medicine and surgery categories as appropriate. Observation stays that result in inpatient admission should be counted in the appropriate category in this measure.

For inpatient utilization, identify discharges designated as "inpatient" by the Type of Bill code (Form Locator 4) on the UB-92 billing form:

11X = Hospital Inpatient (Including Medicare Part A)

OR

41X = Christian Science Hospital Inpatient (Including Medicare Part A)

OR

12X = Hospital Inpatient (Medicare Part B only)

OR

42X = Christian Science Hospital Inpatient (Medicare Part B only) where X represents any third digit.

Total: Total Inpatient excludes nonacute care, mental health, chemical dependency and newborns. The total should represent the sum of the three categories (medicine, surgery and maternity).

DRG codes: 1-108, 110-384, 392-423 and 439-473, 475-494

OR

ICD-9-CM codes: All principal diagnosis codes excluding 290.x-315.xx, 316, 965.0x, 965.8x, 967.xx, 968.5x and 969.xx, also any inpatient discharged with any ICD-9-CM diagnosis code of V30.x-V39.x.

Maternity: Include all inpatient hospitalizations for maternity-related reasons, including abortions and antepartum stays.

Use the following diagnosis codes to identify obstetrics discharges:

DRG codes: 370-384

OR

ICD-9-CM codes: Principal diagnosis codes 630-676.94 and V24.0

OR

UB-92 Occurrence Code (Form Locator 32-35): Medical Condition Code: H 10

Note: Birthing center deliveries should be included in this measure and be counted as one day of stay.

We recognize that the "V" diagnosis codes V22.x, V23.x, V27.x and V61.5-V61.7 are not correct codes for principal OB inpatient diagnoses, where "x" equals any fourth digit. However, if these codes are present in the inpatient database, report them in this category.

UB-92 Occurrence Code H10 is a medical diagnosis code indicating the last menstrual period, which only applies when the patient is being treated for maternity related conditions.

Surgery:

DRG codes: 1-8, 36-42, 49-63,75-77, 103-108, 110-120, 146-171, 191-201, 209-234, 257-270, 285-293, 302-315, 334-345, 353-365, 392-394, 400-402, 406-408, 415, 439-443, 458, 459, 461, 468, 471, 472, 476-486, 488, 491, 493, 494

OR

ICD-9-CM principal diagnosis codes: When ICD-9-CM codes are used to identify the patients receiving surgical services, it is best to do so by first identifying the "total" above and then removing maternity. The remainder represents medicine/surgery. Identify hospitalizations for surgical care as those who are assigned:

UB-92 Revenue code (Form Locator 42): 36X (Operating Room Services), where X represents any third digit.

Medicine:

DRG codes: 9-35, 43-48, 64-74, 78-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 395-399, 403-405, 409-414, 416-423, 444-457, 460, 462-467, 473, 475, 487, 489, 490, 492

OR

ICD-9-CM principal diagnosis codes: When ICD-9-CM codes are used to identify the patients receiving medical services, it is best to do so by first identifying the "Total" above and then removing maternity. The remainder represents medicine/surgery.

Identify hospitalizations for medical care as those who are <u>not</u> assigned:

UB-92 Revenue code (Form Locator 42): 36X (Operating Room Services), where X represents any third digit.

Notes

- The DRGs in this measure were adopted from Diagnosis Related Groups, Version 10.0, Definitions Manual.
- DRGs 109, 438, and 474 are no longer valid and should not be reported.
- DRGs 469 (principal diagnosis invalid as discharge diagnosis) and 470 (ungroupable) should be counted in the "Total" category only, but not in the categories "Medicine" and "Surgery."
- Regardless of the methodology employed by the health plan to document surgeries, the plan is responsible for verifying how surgeries are being identified.
- Medical and surgical services are reported separately because the factors influencing utilization in these two categories vary. This also enables easier comparisons between ambulatory surgery utilization (refer to the Ambulatory Care measure) and inpatient surgery utilization.

Template Table 5D-1: Inpatient Utilization — General Hospital/Acute Care: Medicaid

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Member Months	Average Length of Stay
Total Inpatient					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Medicine					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Surgery					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Maternity					
10-19					
20-44					
45-64					
Unknown					
Total					
Total Member Months					

Template 5D-2/3: Inpatient Utilization — General Hospital/Acute Care: Commercial and Medicare Risk (reported separately)

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges / 1,000 Members	Days	Days / 1,000 Members	Average Length of Stay
Total Inpatient					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Medicine					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Surgery					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Maternity					
10-19					
20-44					
45-64					
Unknown					
Total					
Total Member Months					

AMBULATORY CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *Observation room stays are counted separately.*
- *Age stratification is more detailed for children and for members age 65 years and older to account for demographic characteristics of the Medicaid and Medicare risk populations.*

Description

This table summarizes utilization of ambulatory services in the following categories: Outpatient Visits (excluding mental health and chemical dependency), Emergency Room Visits, Ambulatory Surgery/Procedures performed in hospital outpatient facilities or freestanding surgical centers, and Observation Room Stays that result in discharge (Observation Room Stays resulting in an inpatient admission are counted in the Inpatient Utilization — General Hospital Acute Care measure.

Specifications

Calculation:

Medicaid: Tables 5E-1a, 5E-1b, 5E-1c and 5E-1d should be constructed using Table 5E-1 as a template. Report Outpatient Visits, Emergency Room Visits, Ambulatory Surgery Procedures, Observation Room Stays and the respective rates /1,000 Member Months for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5E-2a, 5E-2b and 5E-3 should be constructed using Table 5E-2/3 as a template. Report Outpatient Visits, Emergency Room Visits, Ambulatory Surgery Procedures, Observation Room Stays and the respective rates/1,000 Members per Year for members in the payer group that each table addresses.

Outpatient Visits (Evaluation and Management Services)

This category accounts for face-to-face encounters between the practitioner and patient and provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all inclusive. Only those plans with administrative data systems may be able to calculate this measure.

Instructions:

- Report services without regard to type of provider/practitioner or the provider's/practitioner's training or licensing.
- Encourage detailed service reporting, even when the financial reimbursement arrangement does not require it, in order to facilitate comparability and complete reporting.

- Include after-hours, non-emergency urgent care.
- Include nursing home visits.
- Omit surgical procedures, regardless of location of service (these are captured in the ambulatory surgery/procedures tables).
- Exclude services coded as primarily pertaining to mental health or chemical dependency.
- Count each member with an occurrence of a CPT-4 procedure code in the following ranges:

Office or Other Outpatient Services:	
New Patient	99201-99205
Established Patient	99211-99215
Consultations	99241-99245
Home Services:	
New Patient	99341-99343
Established Patient	99351-99353
Prolonged Services:	
Prolonged Physician Services	99354-99355
Comprehensive Nursing Facility Assessments:	99301-99303
Subsequent Nursing Facility Care:	99311-99313
Domiciliary, Rest Home or Custodial Care Services:	
New Patient	99321-99323
Established Patient	99331-99333
Case Management Services:	
Team Conferences	99361-99362
Telephone Calls	99371-99373
Preventive Medicine:	
New Patient	99381-99387
Established Patient	99391-99397
Individual Counseling:	99401-99404
Group Counseling:	99411-99412
Other	99420-99429
Newborn Care:	99432

Other Evaluation and Management Services:

99499

Ophthalmology and Optometry:

92002-92014

Note: In states that use a state-level HCPCS code to identify refractions provided by ophthalmologists and optometrists, these services should also be included. If the plan does not use HCPCS or CPT-4 codes, develop a methodology to count all face-to-face encounters with the following practitioners: primary care physicians, specialists, nurse practitioners, physician assistants, ophthalmologists and optometrists.

Emergency Room Visits

This category measures use of ER services, which are included because they may sometimes be used as a substitute for ambulatory clinic encounters. While patient behavior is a factor in the decision to use an ER rather than a clinic or physician's office, the decision may be a result of insufficient access to primary care. Therefore, trends in ER utilization are an important aspect of total utilization data.

Instructions:

- Each visit to an ER that does not result in an inpatient stay should be counted once, regardless of the intensity of care required during the stay or the length of stay. Patients admitted to the hospital from the ER should not be included in counts of visits. Only visits to emergency rooms should be counted; visits to urgent care centers should not be counted in this measure.
- The unit counted is an "Emergency room visit," which should be identified by:

  UB-92 Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" represents any third digit in this code.

  AND

  UB-92 "Revenue" code (Form Locator 42): 45X (Emergency Room) where "X" represents any third digit in this code,

OR

HCFA 1500 Place of Service code (Item 24b): 23 (Emergency Room)

AND

CPT-4 codes: 10040-69979 or 99281-99288

Ambulatory Surgery/Procedures:

This is an important category to include in ambulatory reporting because many procedures formerly performed during an inpatient stay now are routinely performed on an outpatient basis. Some hospitals have developed large ambulatory surgery centers, and independent surgical centers have been built to accommodate this trend. New technology makes it increasingly possible to perform more complex surgery in ambulatory settings, and a growing number of procedures are performed at a physician's office. However, surgeries/procedures performed in physicians' offices are excluded from this measure.

Instructions:

- Only Ambulatory Surgery/Procedures performed at a hospital outpatient facility or at a freestanding surgery center should be reported. Office-based surgeries/procedures should not be reported.
- The unit counted is an "Ambulatory Surgery/Procedure Encounter," defined as one discrete service date for a specific member at a specific site (regardless of the number of services provided at that site) on that day, for that member.
- Claims with ER revenue codes (Form Locator 42) of 450 or 459 should be excluded from this category and reported under "Emergency Room Visit."
- This category includes surgical procedures, scopics/lithotripsy and heart procedures.
- "Ambulatory Surgery/Procedure Encounters" are identified using two options: Option A (the HCFA 1500) or Option B (the UB-92). Specify which option your plan implements.

  HCFA 1500 Place of Service code (Item 24b): 22 (outpatient hospital) or 24 (ambulatory surgical center)

  AND

  CPT-4 code: All codes included in the HCFA Ambulatory Surgical Center (ASC) Base Eligibility File, 92953, 92970, 92971, 92975, 92980, 92982, 92986, 92990, 92992, 92993, 92995, 93501-93536, 93600-93652.

  Note: The HCFA ASC Base Eligibility File is available through the Bureau of Data Management and Strategy at (410) 786-3691.

OR

UB-92 Type of Bill code (Form Locator 4): 13X (Hospital outpatient), 43X (Christian Science hospital outpatient) or 83X (Specialty facility outpatient), where "X" represents any third digit in this code.

AND

UB-92 Revenue code (Form Locator 42):

36X (Operating room services),

49X (Ambulatory surgical care),

75X (Gastrointestinal services),

79X (Lithotripsy),

480 (Cardiology general classification),

481 (Cardiac cath lab),

320 (Radiology-diagnostic general classification),

321 (Angiocardiography) or

323 (Arteriography),

where "X" represents any third digit in this code.

AND

ICD-9-CM procedure codes: Codes 01.0 through 86.99, 88.42, 88.50-88.58 or 98.51-98.59.

Note: *Use of the HCFA 1500 and CPT-4 codes is the preferred method for this measure. When it is necessary for the plan to use both methods (i.e., the HCFA 1500 and the UB-92), the plan is responsible for avoiding double-counting.*

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Observation room stays are increasingly used to determine whether the condition of a patient necessitates inpatient admission. Trends in utilization of observation rooms are an important aspect of total utilization data.

Instructions:

- Each stay in an observation room that does not result in an inpatient stay should be counted once, regardless of the intensity of care required during the stay or the length of time spent. Patients admitted to the hospital from the observation unit (whose observation unit stay would be billed on an inpatient bill) should not be included this measure.
- Claims with ER revenue codes (Form Locator 42) of 450 or 459 should be excluded from this category and reported under "Emergency Room Visits." Claims with Ambulatory Surgery revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321 or 323) should be excluded from this category and reported under "Ambulatory Surgery/Procedures."
- The unit counted is an "Observation room stay," which should be identified by:

  UB-92 Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" represents any third digit in this code.

  AND

  UB-92 Revenue code (Form Locator 42): 762 (Observation Room)

Notes

- This measure does not attempt to capture observation services exhaustively. Because current coding does not allow data to be obtained on comparable observation services from facility-based and professional claims, a more restrictive approach was chosen, recognizing that not all observation services will be captured, but that data reported will be more comparable.
- UB-92 revenue codes 760 and 769 should not be included. Although some observation room stays may be coded with these revenue codes, other visits and services not classified as observation room stays would be captured.
- Observation stays with a principal diagnosis of mental health and chemical dependency should not be reported in this measure. Mental health and chemical dependency services are reported in tables 5J to 5O.

Template Table 5E-1: Ambulatory Care: Medicaid

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

	Outpatient Visits (Excludes MH/CD)		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
Age	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Procedures	Procedures/1,000 Member Months	Stays	Stays/1,000 Member Months
<1								
1-9								
10-19								
20-44								
45-64								
65-74								
75-84								
85+								
Unknown								
Total								

Template Table 5E-2/3: Ambulatory Care: Commercial and Medicare Risk (reported separately)

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

	Outpatient Visits (Excludes MH/CD)		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
Age	Visits	Visits/1,000 Members	Visits	Visits/1,000 Members	Procedures	Procedures/1,000 Members	Stays	Stays/1,000 Members
<1								
1-9								
10-19								
20-44								
45-64								
65-74								
75-84								
85+								
Unknown								
Total								

INPATIENT UTILIZATION — NONACUTE CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *Age stratification is more detailed for children and members age 65 years and older, to account for demographic characteristics of the Medicaid and Medicare risk populations.*

Description

This table summarizes utilization of nonacute inpatient care in the following facilities: hospice, nursing home, rehabilitation, SNF, transitional care and respite. These data excludes mental health and chemical dependency.

Specifications

Calculation:

Medicaid: Tables 5F-1a, 5F-1b, 5F-1c and 5F-1d are constructed using Table 5F-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days, Days/1,000 Member Months and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5F-2a, 5F-2b and 5F-3 are constructed using Table 5F-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days, Days/1,000 Members per Year and Average Length of Stay for members in the payer group that the table addresses.

Nonacute Care is defined as:

➤ UB-92 Type of Bill code (Form Locator 4):

Hospice = codes 81X or 82X

OR

SNF = codes 21X or 22X

OR

Hospital transitional care, swing bed or rehabilitation = code 18X, where "X" represents any third digit.

OR

➤ UB-92 Revenue codes (Form Locator 42):

Hospice = codes 115, 125, 135, 145, 155, 650 or 659

OR

Rehabilitation = codes 118, 128, 138, 148, 158

OR

Respite = code 655.

OR

➤ Other nonacute care facilities that do not use the UB-92 for billing (ICF, SNF, etc.).

Include data from any institution that provides long-term/specialty nonacute care. Each plan should identify the appropriate codes.

Template Table 5F-1: Inpatient Utilization — Nonacute Care: Medicaid

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

Template Table 5F-2/3: Inpatient Utilization — Nonacute Care: Commercial and Medicare risk (reported separately)

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Age	Discharges	Discharges/1,000 Members	Days	Days/1,000 Members	Average Length of Stay
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

DISCHARGE AND AVERAGE LENGTH OF STAY — MATERNITY CARE

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *At-home deliveries should not be counted in this measure.*
- ➤ *Medicaid HEDIS age stratification has been adopted.*
- ➤ *In addition to Discharges and Days, health plans will report the following for vaginal and Cesarean section deliveries: Discharges/1,000 Member Months and Days/1,000 Member Months for Medicaid members and Discharges/1,000 Members per Year and Days/1000 Members per year for commercial members.*

Description

This table summarizes utilization information on maternity-related care for enrolled females who had live births during the reporting year. This information is reported for total deliveries, vaginal deliveries and Cesarean section deliveries.

Specifications

Calculation:

Medicaid: Tables 5G-1a, 5G-1b, 5G-1c and 5G-1d are constructed using Table 5G-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days, Days/1,000 Member Months and Average Length of Stay for female members in the Medicaid eligibility category that each table addresses.

Commercial: Tables 5G-2a and 5G-2b are constructed using Table 5G-2 as a template. Report Discharges, Discharges/1,000 Members per Year, Days, Days/1,000 Members per Year and Average Length of Stay for female members in the payer group that each table addresses.

Note: *Plans often use several sources to ensure the completeness and validity of live-birth information. Codes used for this table are differentiated by their ability to denote deliveries resulting in a live birth; some codes may be used alone, while others are used to supplement the plan's search to identify live births (e.g., V codes may be used alone; CPT-4 procedure codes are used in conjunction with ICD-9-CM diagnosis codes). Regardless of the method employed by the health plan to document live births, the plan is responsible for verifying that only live births are included in this measure.*

Note: *Plans should document the percentage of their maternity population that was hospitalized in jurisdictions that have mandated (a) minimum covered length(s) of stay for maternity, for vaginal and cesarean section deliveries. Specify the minimum length(s) of stay.*

Total Deliveries Resulting in Live Births

Plans should identify all live births delivered in an inpatient setting and at birthing centers. At-home deliveries are not counted in this measure. In calculating the length of stay, both pre-delivery and post-delivery days are included. Birthing center deliveries are counted as one day of stay. Count multiple births as one delivery.

The sum of Cesarean sections and vaginal deliveries should equal this total.

DRG codes: 370-375. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM codes: An ICD-9-CM diagnosis code of 650.

OR

V codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

To verify ICD-9-CM codes for live births, CPT-4 codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 or 59622 may be used in conjunction with one or more of the ICD-9-CM codes listed above.

Cesarean Section

Identify Cesarean section deliveries using:

DRG codes: 370-371. Only deliveries resulting in live births should be included. The plan is responsible for documenting its method for validating live births when using DRGs.

OR

ICD-9-CM procedure codes: 74.0-74.2, 74.4, and 74.99 or CPT-4 codes 59510, 59514, 59515, 59618, 59620 and 59622 in conjunction with one or more of the following ICD-9-CM diagnosis code or V codes:

ICD-9-CM code: An ICD-9-CM diagnosis code of 650.

OR

V codes: A V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the health plan to document live births. The plan must document the method, including codes used, for validating live births.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

Vaginal Delivery

DRG codes: 372-375. Only deliveries resulting in live births should be included.

OR

ICD-9-CM codes: This is a residual category. It equals those discharges remaining after removing Cesarean sections from the total deliveries that result in live births.

Note: CPT-4 procedure codes 59400, 59409 59410, 59610, 59612 or 59614 in conjunction with an appropriate ICD-9-CM diagnosis code may be used to identify vaginal deliveries. Only vaginal deliveries resulting in live births should be included.

Template Table 5G-1: Discharge and Average Length of Stay — Maternity Care: Medicaid

Age	Female Member Months
10-14	
15-19	
20-34	
35-49	
Other*	
Total	

Age	Discharges	Discharges/1,000 Female Member Months	Days	Days/1,000 Female Member Months	Average Length of Stay
Total Deliveries					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Vaginal Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Cesarean Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

* "Other" includes females age 0-9, 50+ and of unknown age.

Template Table 5G-2: Discharge and Average Length of Stay — Maternity Care: Commercial

Age	Female Member Months
10-14	
15-19	
20-34	
35-49	
Other*	
Total	

Age	Discharges	Discharges/1,000 Female Members	Days	Days/1,000 Female Members	Average Length of Stay
Total Deliveries					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Vaginal Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					
Total Cesarean Deliveries: Live Births					
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

* "Other" includes females age 0-9, 50+ and of unknown age.

CESAREAN SECTION RATE AND VAGINAL BIRTH AFTER CESAREAN SECTION RATE (VBAC-RATE)

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *Medicaid HEDIS age stratification has been adopted.*
- ➤ *Calculation of the C-Section rate is required.*
- ➤ *The measure Vaginal Birth After Cesarean Section Rate (VBAC Rate) is not required for the 1996 reporting year. It is being deferred because of the persistent problems with the identification of numerator and denominator for this rate from administrative data sources. Health plans should develop a method to track VBACs and repeated Cesarean Sections, e.g., utilizing the newly introduced CPT-4 codes 59610-59622. This measure will be required for the 1997 reporting year.*

Description

These tables summarize utilization information (Days, Average Length of Stay) for female members having a Cesarean section resulting in a live birth or giving vaginal birth to a live newborn during the reporting year after a prior Cesarean section. The C-Section rate and the VBAC rate are calculated.

Specifications

Calculation: Tables 5H-1a, 5H-1b, 5H-1c and 5H-1d for Medicaid members and Tables 5H-2a and 5H-2b for commercial members should be constructed using Table 5H as a template.

Cesarean Section Rate

This table can be completed by transferring data from the Discharge and Average Length of Stay — Maternity Care measure, and calculating the C-section rate.

The C-section rate is:

Denominator: Number of women who had a delivery (vaginal or Cesarean section) resulting in a live birth during the reporting year.

Numerator: Number of women who had a C-section resulting in a live birth during the reporting year.

Rate of Vaginal Deliveries after Cesarean Section (VBAC Rate)

To identify Vaginal Birth after Cesarean Section use the following:

ICD-9-CM diagnosis code of 654.2x (where x equals any fifth digit) or CPT-4 codes 59610, 59612 or 59614, in conjunction with one or more of the following ICD-9-CM diagnosis code or V codes:

ICD-9-CM code: An ICD-9-CM diagnosis code of 650.

OR

V-codes: V code of V27.0, V27.2, V27.3, V27.5 or V27.6.

OR

An equivalent method used by the health plan to document live births. The plan must document the method, including codes used, for validating live births.

DRG codes are not applicable in calculating VBAC rate.

Suggestion for verifying live births

To verify V codes for live births, the following ICD-9-CM diagnosis codes may be used:

640.0x-648.9x with a fifth digit equal to "1" or "2"

OR

651.0x-656.3x with a fifth digit equal to "1" or "2"

OR

656.5x-676.9x with a fifth digit equal to "1" or "2"

OR

669.5x-669.7x

Note: *CPT-4 codes 59400, 59409 or 59410 may be used in conjunction with the ICD-9-CM diagnosis codes listed above, or with V-codes V27.0, 27.2, V27.3, V27.5 or V27.6 to verify live births.*

The VBAC rate is:

Denominator: Number of women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year and who had a previous C-section.

Numerator: Number of women who had a vaginal delivery resulting in a live birth during the reporting year and who had a previous C-section.

Note: *Plans should look as far back as possible for previous C-sections. Either administrative data or medical records may be used.*

Template Table 5H: Cesarean Section Rate and VBAC Section Rate: Medicaid and Commercial (reported separately)

Age	Discharges: Cesarean Deliveries	Days	Average Length of Stay	Discharges: Total Deliveries	C-Section Rate
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

Age	Discharges: Vaginal Deliveries with Prior C-Section	Days	Average Length of Stay	Discharges: Total Deliveries with Prior C-Section	VBAC Rate
10-14					
15-19					
20-34					
35-49					
Other*					
Total					

* "Other" includes females age 0-9, 50+ and of unknown age.

BIRTHS AND AVERAGE LENGTH OF STAY, NEWBORNS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This table has been modified to facilitate adding newborn utilization rates to utilization rates reported in the Inpatient Utilization - General Hospital/Acute Care measure.*
- ➤ *Stratification of utilization data for newborns by maternal age has been deleted.*

Description

This table summarizes utilization information on newborns during the reporting year. This information is reported on total newborns, well newborns and complex newborns.

Specifications

Calculation:

Medicaid: Tables 5I-1a, 5I-1b, 5I-1c and 5I-1d are constructed using Table 5I-1 as a template. Report Total Number of Newborns, Newborns/1,000 Female Member Months, Newborns/1,000 Member Months, Days, Days per 1,000 Member Months, and Average Length of Stay for the newborns in the Medicaid eligibility category that each table addresses.

Commercial: Tables 5I-2a and 5I-2b are constructed using Table 5I-2 as a template. Report Total Number of Newborns, Newborns/1,000 Female Members per Year, Newborns/1,000 Members per Year, Days, Days per 1,000 Members per Year, and Average Length of Stay for newborns in the payer group that each table addresses.

Definition of Newborn Care

Newborns are identified and reported separately from maternity members. Newborn care is defined as care provided from birth to discharge to home. If a newborn is transferred from one hospital to another and has never gone home, the care is still newborn care.

Newborns born in an inpatient setting and at birthing centers should be included in this measure. For newborns delivered in birthing centers, count one day of stay.

Some health plans do not keep separate records on well newborns. An approximation that counts the number of newborns and days associated with their stays should be developed by plans that do not have separate discharge abstracts for newborns who leave the hospital at the same time as their mother. For example, use the mother's length of stay as a proxy for the well newborn's length of stay. To allow for instances in which the mother is not a member of the plan but the newborn is a member, plans may also need to develop a method that links the newborn to the mother. Provide documentation for the approach used.

USE OF SE

Total Newborns

Plans that complete discharge abstracts for newborns should use:

DRG codes: 385 - 391.

OR

ICD-9-CM codes: Any inpatient discharge with a principal or other ICD-9-CM diagnosis code of V30.x-V39.x (this excludes stillborns).

Newborns are further separated into complex and well newborns.

Complex Newborns

Newborns are identified as complex if: 1) their LOS is greater than or equal to five days or 2) their LOS is less than five days and the newborn expired. Expired newborns are those with a patient status code (Form Locator 22) equal to 20-29.

Well Newborns

Well newborns are newborns who are not defined as complex and have LOS of less than five days.

Notes

- The specifications do not address newborns transferred to another facility. If a health plan has the capability to link discharges for transferred newborns, the LOS calculations should reflect both discharges combined. If a health plan does not have this capability, the transferred newborns should be classified as complex. Under no circumstances should a newborn be counted more than once. Refer to Table 1F to identify and count multiple births.
- Newborns who are not members of the health plan at the time of birth should not be counted in Table 5I.
- The CPM recognizes that the definition of well and complex newborns on the basis of the length of stay has problems. A methodology to identify well and complex newborns based on clinical coding is being developed and evaluated.
- Health plans should document the percentage of their newborn population that was hospitalized in jurisdictions that have mandated a minimum covered LOS for newborns and specify the minimum length(s) of stay.

Template Table 5I-1: Births and Average Length of Stay, Newborns: Medicaid

Total Member Months (All Ages) _____

Total Female Member Months (10-49) _____

	Number of Newborns	Newborns/1,000 Female Member Months (10-49)	Newborns, Discharges/ 1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
All Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Well Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Complex Newborns						
Mother is Plan Member						
Mother not Plan Member*						

* Include all covered babies born to mothers who are not members of the health plan.

Template Table 5I-2: Births and Average Length of Stay, Newborns: Commercial

Total Member Months (All Ages) _____

Total Female Member Months (10-49) _____

	Number of Newborns	Newborns/1,000 Female Members per Year (10-49)	Newborns, Discharges/1,000 Members per Year	Days	Days/1,000 Members per Year	Average Length of Stay
All Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Well Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Complex Newborns						
Mother is Plan Member						
Mother not Plan Member*						

* Include all covered babies born to mothers who are not members of the health plan.

MENTAL HEALTH UTILIZATION — INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

This table summarizes utilization of inpatient mental health services, stratified by age and sex.

Specifications

Calculation:

Medicaid: Tables 5J-1a, 5J-1b, 5J-1c and 5J-1d are constructed using Table 5J-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days of Inpatient Care and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5J-2a, 5J-2b and 5J-3 are constructed using Table 5J-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days and Average Length of Stay for members in the payer group that the table addresses.

Refer to the algorithm provided on the following pages to identify inpatient care.

Note: *Table 5J should reflect inpatient days only. Days associated with day/night or partial hospitalization should be excluded.*

Template Table 5J: Mental Health Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Medicaid

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Member Months	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

* This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

Template Table 5J-2/3: Mental Health Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Commercial and Medicare Risk (reported separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Members	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

* This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

MENTAL HEALTH UTILIZATION — PERCENTAGE OF MEMBERS RECEIVING INPATIENT, DAY/NIGHT CARE AND AMBULATORY SERVICES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*
- ➤ *Codes have been modified.*

Description

This measure reports the number and percentage of members receiving mental health services during the reporting year in the following categories: Any Mental Health Services (inpatient, day/night, ambulatory), Inpatient Mental Health Services, Day/Night Mental Health Services and Ambulatory Mental Health Services. Report in each category the number of members who received the respective service and, of all enrollees with a mental health benefit, the percentage who received the respective service. This information is reported by age and sex.

This table is intended to give an overview of the extent to which the plan uses the different levels of mental health care.

Specifications

Calculation:

Medicaid, Commercial and Medicare Risk: Tables 5K-1a, 5K-1b, 5K-1c, 5K-1d, 5K-2a, 5K-2b and 5K-3 are constructed using Table 5K as a template. Report the number and percentage of health plan members in the payer/eligibility group that each table addresses who receive Any Mental Health Services, Inpatient, Day/Night or Ambulatory Mental Health Services.

Refer to the algorithm provided on the following pages to identify inpatient, day/night and ambulatory care. A member could be counted in all four columns if he/she has received inpatient, day/night and ambulatory mental health services. A member should be counted in each column only once, regardless of his/her number of visits.

In each column, for members who have had more than one encounter, count the first visit in the reporting year and report the member in the respective age category as of the date of discharge.

Notes

- Because some health plans may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of this table may vary. The denominator in the column "any mental health services" should reflect all enrollees who have any mental health benefit.
- Member months of enrollment of members with the respective benefit are used as the denominator for calculating the percentage of members receiving any mental health services, inpatient, day/night or ambulatory mental health services. Other methods of defining the denominators are being considered for future versions of HEDIS.

Template Table 5K: Mental Health Utilization — Percent of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services: Medicaid, Commercial and Medicare Risk (reported separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

		Any Mental Health Services		Inpatient Mental Health Services		Day/Night Mental Health Services		Ambulatory Mental Health Services	
Age	**Sex**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-12	Male								
	Female								
	Total								
13-17	Male								
	Female								
	Total								
18-64	Male								
	Female								
	Total								
65+	Male								
	Female								
	Total								
Unknown	Male								
	Female								
	Total								
Total	Male								
	Female								
	Total								

Algorithm for identifying inpatient, day/night and ambulatory services, to be used as appropriate to complete Tables 5J and 5K:

Three levels of mental health utilization are assessed: inpatient, day/night and ambulatory. The day/night category captures the growing segment of partial hospitalizations.

Inpatient: Inpatient care for mental health diagnoses, at either a hospital or a treatment facility:

DRG codes: 424-432

OR

ICD-9-CM codes: Principal diagnosis codes in the range of 290.xx, 293.xx-302.xx and 306.xx-316.xx. Note that diagnosis codes 317-319 should be reported as medicine or surgery (Tables 5F-1).

Note: DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.

Day/Night Care: Mental health and chemical dependency services are difficult to count as separate reporting entities because unique CPT-4 codes do not currently exist for chemical dependency services. However, mental health can be separated from chemical dependency, because it is common practice to use identical psychiatry CPT-4 codes accompanied by specific ICD-9-CM codes to separate the type of services rendered. Although this approach is less than perfect, it will help gain a better understanding of resource use in this area of great public concern.

Instructions:

- Use CPT-4 code ranges accompanied by ICD-9-CM codes to separate mental health and chemical dependency. ICD-9-CM codes should be consistent with those used to capture inpatient discharges. The principal diagnosis code reported on the claim should be used regardless of overlapping MH/CD problems in an individual case. Services provided by nonphysician practitioners should be counted the same as those provided by physicians.

  Include all other ambulatory care MH/CD service day treatment and partial hospitalization programs, because these programs represent a significant amount of services rendered. These services could be represented by Level III HCPCS codes. They are reported under day/night care, separate from ambulatory services.

  Exclude any utilization the plan knows is designated as "inpatient" by the part of the type of bill code that refers to location of service.

- Count the following CPT-4 procedure codes only if they appear in conjunction with the ICD-9-CM diagnosis codes for mental health (290.xx, 293.xx-302.xx, 306.xx-316.xx):

90801	Diagnostic Assessment
90820	Interactive Interview Examination
90841	MD Psychotherapy
90842	MD Psychotherapy
90843	MD Psychotherapy

90844	MD Psychotherapy
90845	MD Psychoanalysis
90846	Family Psychotherapy without Patient
90847	Family Psychotherapy
90849	Multifamily Group Therapy
90853	Group Psychotherapy
90855	Interactive Individual Medical Psychotherapy
90857	Interactive Group Medical Psychotherapy
90862	Pharmacology Management
90870-90871	Electroconvulsive Therapy

Exclude the following CPT-4 codes from this category:

90880	Medical Hypnotherapy
90882	Environmental Intervention
90887	Interpretation of Tests
90889	Preparation of Reports
90900-90915	Biofeedback

Note: *Because more than 90% of mental health services can be captured with a minimal number of codes, collection of these additional and extraneous codes above is too costly for a relatively small gain in data. In addition, codes used for hypnotherapy and biofeedback can be applied to non-mental health services, which makes their reporting problematic for this category.*

Separate the CPT-4 codes identified in Step 2, in conjunction with the ICD-9-CM codes, into day/night care as follows:

Revenue code (Form Locator 42): 912 (Psychiatric/psychological services-partial hospitalization)

AND

Type of Bill code (Form Locator 4): 13X (hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Ambulatory: To identify ambulatory services, repeat Steps 1 and 2 above under day/night care, and separate ambulatory as follows:

Revenue code (Form Locator 42):

900 (Psychiatric/Psychological Treatments, General Classification), or

901 (Psychiatric/Psychological Treatments, Electroshock Treatment), or

902 (Psychiatric/Psychological Treatments, Milieu Therapy), or

903 (Psychiatric/Psychological Treatments, Play Therapy), or

909 (Psychiatric/Psychological Treatments, Other), or

910 (Psychiatric/Psychological Services, General Classification), or

911 (Psychiatric/Psychological Services, Rehabilitation), or

914 (Psychiatric/Psychological Services, Individual Therapy), or

915 (Psychiatric/Psychological Services, Group Therapy), or

916 (Psychiatric/Psychological Services, Family Therapy), or

918 (Psychiatric/Psychological Services, Testing), or

919 (Psychiatric/Psychological Services, Other).

AND

Type of Bill code (Form Locator 4): 13X (Hospital Outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Note: *Ambulatory services delivered in any setting (hospital outpatient clinic, physician's office, etc.) should be counted as ambulatory services in Tables 5K-1. Plans will only need to use the revenue code and type of bill code to separate ambulatory from inpatient services if data from the UB-92 are used.*

READMISSION FOR SELECTED MENTAL HEALTH DISORDERS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *This measure was broadened to include the mental health diagnoses specified in Medicaid HEDIS, in order to be consistent with the Follow-Up After Hospitalization for Mental Illness measure in the Effectiveness of Care domain.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

The number of members readmitted within 90 and 365 days of hospitalization for selected mental health disorders and the percentages of those rehospitalized versus the number of all members hospitalized for these mental health disorders in the year before the reporting year. This information is reported by age and sex.

This measure is intended to help assess the extent of rehospitalization required after inpatient mental health treatment.

Specifications

Calculation:

Medicaid, Commercial and Medicare risk: Tables 5L-1a, 5L-1b, 5L-1c, 5L-1d, 5L-2a, 5L-2b and 5L-3 are constructed using Table 5L as a template. Report the number of members, by age and sex, hospitalized for any selected mental health disorder in the year prior to the reporting year, and the number and percentage of these members who were readmitted for any selected mental health disorder within 90 days and within 365 days after discharge.

Note: *This measure applies to inpatient admissions and readmissions only; day/night care should not be included.*

The Selected Mental Health Disorders are defined by a principal diagnosis of:

ICD-9-CM 295.xx	Schizophrenic disorders
ICD-9-CM 296.0x	Manic disorder, single episode
ICD-9-CM 296.1x	Manic disorder, recurrent episode
ICD-9-CM 296.2x	Major depressive disorder, single episode
ICD-9-CM 296.3x	Major depressive disorder, recurrent episode
ICD-9-CM 296.4x	Bipolar affective disorder, manic
ICD-9-CM 296.5x	Bipolar affective disorder, depressed
ICD-9-CM 296.6x	Bipolar affective disorder, mixed

ICD-9-CM	296.7x	Bipolar affective disorder, unspecified
ICD-9-CM	296.8x	Manic-depressive psychosis, other and unspecified
ICD-9-CM	296.9x	Other and unspecified affective psychoses
ICD-9-CM	297.x	Paranoid states
ICD-9-CM	298.x	Other nonorganic psychoses
ICD-9-CM	299.xx	Psychoses with origin specific to childhood
ICD-9-CM	301.x	Personality disorders
ICD-9-CM	308.x	Acute reaction to stress
ICD-9-CM	309.xx	Adjustment reaction
ICD-9-CM	311	Depressive disorder, not otherwise classified
ICD-9-CM	312.xx	Disturbance of conduct, not elsewhere classified
ICD-9-CM	313.xx	Disturbance of emotions specific to childhood and adolescence
ICD-9-CM	314.xx	Hyperkinetic syndrome of childhood

Instructions:

- Identify all potential discharges during the year prior to the reporting year (calendar year 199x-1) for each member with a principal diagnosis listed above. If a member had more than one discharge, use the latest discharge, which becomes the "index episode." Exclude index episodes for those members not continuously enrolled for 365 days (allowing no more than one break in service not to exceed 45 days) after the discharge date of the index episode.
- For all remaining index episodes, indicate whether the member was readmitted to an inpatient hospital within 365 days of the latest discharge for related care of one of the selected mental health disorders. Count only readmissions that occur during the reporting year. To determine if an episode is related care, search the diagnosis codes (up to the first five ICD-9-CM codes) associated with the episode for one or more of the mental health diagnosis codes identified above. If at least one of the first five ICD-9-CM codes relates to one of the selected mental health disorders, the episode is considered a related readmission. Count one readmission per member.
- To obtain the 90-day readmission rate, identify those members who were readmitted within 365 days for related care of one of the selected mental health disorders and identify the subset that represents readmissions within 90 days.

Notes

- There are a number of ways to calculate readmission rates. While the method used here misses readmissions that occur during the same calendar year, it does detect readmissions within a specific time window, thus allowing comparison among health plans. A method allowing more complete capturing of readmissions is being developed and evaluated.
- Classify members according to their age as of the discharge date from the index episode.

Template Table 5L: Readmission for Selected Mental Health Disorders: Medicaid, Commercial and Medicare Risk (reported separately)

Age	Sex	Hospitalized in Year Prior to Reporting Year	Readmitted within 90 Days of Prior Year's Index Discharge		Readmitted with 365 Days of Prior Year's Index Discharge	
			Number	Percent	Number	Percent
0-12	Male					
	Female					
	Total					
13-17	Male					
	Female					
	Total					
18-64	Male					
	Female					
	Total					
65+	Male					
	Female					
	Total					
Unknown	Male					
	Female					
	Total					
Total	Male					
	Female					
	Total					

Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

This table summarizes utilization of inpatient chemical dependency services, stratified by age and sex.

Specifications

Calculation:

Medicaid: Tables 5M-1a, 5M-1b, 5M-1c and 5M-1d, are constructed using Table 5M-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5M-2a, 5M-2b and 5M-3 are constructed using Table 5M-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days and Average Length of Stay for members in the payer group that each table addresses.

Refer to the algorithm provided on the following pages to identify inpatient care.

Note: Tables 5M should reflect inpatient days only. Exclude days associated with day/night or partial hospitalization.

USE OF SERV

Template Table 5M-1: Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Medicaid

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Member Months	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

*This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

Template Table 5M-2/3: Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Commercial and Medicare Risk (reported Separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Members	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

*This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

CHEMICAL DEPENDENCY UTILIZATION — PERCENTAGE OF MEMBERS RECEIVING INPATIENT, DAY/NIGHT CARE AND AMBULATORY SERVICES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- *A subtotal, summarizing data on male and female members in each age group, is provided.*
- *Codes have been modified.*

Description

This measure reports the number and percentage of members receiving chemical dependency services during the reporting year in the following categories: Any Chemical Dependency Services (inpatient, day/night, ambulatory), Inpatient Chemical Dependency Services, Day/Night Chemical Dependency Services and Ambulatory Chemical Dependency Services. Report in each category the number of members who received the respective service and, of all enrollees with a chemical dependency benefit, the percentage that received the respective service. This information is reported by age and sex.

This table is intended to give an overview of the extent to which the plan uses the different levels of chemical dependency care.

Specifications

Calculation:

Medicaid, Commercial and Medicare risk: Tables 5N-1a, 5N-1b, 5N-1c, 5N-1d, 5N-2a, 5N-2b and 5N3 are constructed using Table 5N as a template. Report the number and percent of health plan members in the respective age and sex group who receive any chemical dependency services, inpatient, day/night or ambulatory chemical dependency services.

Refer to the algorithm provided on the following pages to identify inpatient, day/night and ambulatory care. A member could be counted in all four columns if he/she has received inpatient, day/night and ambulatory chemical dependency services. A member should be counted in each column only once, regardless of his/her number of visits.

In each column, for members who have had more than one encounter, count the first visit in the reporting year and report the member in the respective age category as of the date of discharge.

Note

- Member months of enrollment of members with the respective benefit are used as the denominator for calculating the percentage of members receiving any mental health services, inpatient, day/night or ambulatory mental health services. Other methods of defining the denominators are being considered for future versions of HEDIS.

Template Table 5N: Chemical Dependency Utilization — Percent of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services: Medicaid, Commercial and Medicare Risk (reported separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

		Any Chemical Dependency Services		Inpatient Chemical Dependency Services		Day/Night Chemical Dependency Servoces		Ambulatory Chemical Dependency Services	
Age	**Sex**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-12	Male								
	Female								
	Total								
13-17	Male								
	Female								
	Total								
18-64	Male								
	Female								
	Total								
65+	Male								
	Female								
	Total								
Unknown	Male								
	Female								
	Total								
Total	Male								
	Female								
	Total								

Algorithm for identifying inpatient, day/night and ambulatory services, to be used as appropriate to complete Tables 5M and 5N:

Three levels of chemical dependency treatment utilization are assessed: inpatient, day/night and ambulatory. The day/night category captures the growing segment of partial hospitalizations.

Inpatient: Inpatient care with chemical dependency as the principal diagnosis, including detoxification, at either a hospital or a treatment facility.

DRG codes: 433-437.

OR

ICD-9-CM codes: Principal diagnosis codes in the range of 291-292.9, 303.0-305.93, 965.0x, 965.8x, 967.xx, 968.5x or 969.xx.

Note: *ICD-9-CM code 967.xx may be used to identify chemical dependency in conjunction with a secondary diagnosis of dependency or other data source that substantiates chemical dependency.*

Note: *Diagnosis codes 980.0-980.9 should be reported as medicine or surgery (Tables 5F-1).*

Note: *DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use them and document it. Follow the specifications outlined above for ICD-9-CM codes.*

Day/Night Care: Mental health and chemical dependency services are difficult to count as separate reporting entities because unique CPT-4 codes do not currently exist for chemical dependency services. However, mental health can be separated from chemical dependency because it is common practice to use identical psychiatry CPT-4 codes accompanied by specific ICD-9-CM codes to separate the types of services provided. Although this approach is less than perfect, it will help gain a better understanding of resource use in this area of great public concern.

Instructions:

➤ Use CPT-4 code ranges accompanied by ICD-9-CM codes to separate mental health and chemical dependency. ICD-9-CM codes should be consistent with those used to capture inpatient discharges. The principal diagnosis code reported on the claim should be used regardless of overlapping MH/CD problems in an individual case. Services provided by nonphysician practitioners should be counted the same as those provided by physicians.

Include all other ambulatory care MH/CD service day treatment and partial hospitalization programs, because these programs represent significant services rendered. These services could be represented by Level III HCPCS codes. They are reported under day/night care, separate from ambulatory services. Exclude any utilization the plan knows is designated as "inpatient" by the part of the type of bill code that refers to location of service.

➤ Count the following CPT-4 procedure codes only if they appear in conjunction with the ICD-9-CM diagnoses codes for chemical dependency (291-292.9, 303.0-305.93, 965.0x, 965.8x, 967.xx, 968.5x or 969.xx):

90801	Diagnostic Assessment
90820	Interactive Interview Examination
90841	MD Psychotherapy
90842	MD Psychotherapy
90843	MD Psychotherapy
90844	MD Psychotherapy
90845	MD Psychoanalysis
90846	Family Psychotherapy without Patient
90847	Family Psychotherapy
90849	Multifamily Group Therapy
90853	Group Psychotherapy
90855	Interactive Individual Medical Psychotherapy
90857	Interactive Group Medical Psychotherapy
90862	Pharmacology Management
90870-90871	Electroconvulsive Therapy

Exclude the following CPT-4 codes from this category:

90880	Medical Hypnotherapy
90882	Environmental Intervention
90887	Interpretation of Tests
90889	Preparation of Reports
90900-90915	Biofeedback

Note: *Because more than 90% of mental health services can be captured with a minimal number of codes, collection of these additional and extraneous codes for this measure is too costly for a relatively small gain in data. In addition, codes used for hypnotherapy and biofeedback can be applied to non-mental health services, rendering their reporting problematic for this category.*

➤ Separate the CPT-4 codes identified in Step 2, in conjunction with the ICD-9-CM codes, into day/night care as follows:

Revenue code (Form Locator 42): 912 (Psychiatric/psychological services-partial hospitalization)

AND

Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Ambulatory: To identify ambulatory services, repeat Steps 1 and 2 above under day/night care and separate ambulatory as follows:

Revenue code (Form Locator 42): 944 (Drug rehabilitation) or 945 (Alcohol rehabilitation)

AND

Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Note: *Ambulatory services delivered in any setting (hospital outpatient clinic, physician's office, etc.) should be counted as ambulatory services in Tables 5N-1. Plans will only need to use the revenue code and type of bill code to separate ambulatory from inpatient services if data from the UB-92 are used.*

READMISSION FOR CHEMICAL DEPENDENCY

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

This measure reports the number of members readmitted within 90 and 365 days of hospitalization for chemical dependency treatment and the percentages of those rehospitalized versus the number of all members hospitalized for chemical dependency treatment in the year before the reporting year. This information is reported by age and sex.

This table is intended to help assess the extent of rehospitalization required after inpatient chemical dependency treatment.

Specifications

Calculation:

Medicaid, Commercial and Medicare Risk: Tables 5O-1a, 5O-1b, 5O-1c, 5O-1d, 5O-2a, 5O-2b, 5O-3 are constructed using Table 5O as a template. Report the number of members hospitalized for chemical dependency in the year prior to the reporting year and the number and percentage of these members who were readmitted for chemical dependency treatment within 90 days and within 365 days after discharge.

Note: This measure applies to inpatient admissions and readmissions only; day/night care should not be included.

ICD-9-CM codes: Principal diagnosis codes in the range of 291-292.9, 303.0-305.93, 965.0x, 965.8x, 967.xx, 968.5x or 969.xx.

Diagnosis codes 980.0-980.9 should be reported as medicine or surgery (Table 5F-1).

Instructions:

- ➤ Identify all potential discharges during the year prior to the reporting year (calendar year 199x-1) for each member with a principal diagnosis listed above. If a member had more than one discharge, take the latest discharge, which becomes the "index episode." Exclude index episodes for those members not continuously enrolled for 365 days (allowing no more than one break in service, not to exceed 45 days) after the discharge date of the index episode.
- ➤ For all remaining index episodes, indicate whether the member was readmitted to an inpatient hospital within 365 days of the latest discharge for related care of chemical dependency. Only count readmissions that occur during the reporting year. To determine if an episode is related care, search the diagnosis codes (up to

the first five ICD-9-CM codes) associated with the episode for one or more of the chemical dependency codes identified above. If at least one of the first five ICD-9-CM codes relates to chemical dependency, consider the episode to be a related readmission. Count one readmission per member.

➤ To obtain the 90-day readmission rate, identify those members who were readmitted within 365 days for related care of chemical dependency and identify the subset that represents readmissions within 90 days.

Notes

➤ There are a number of ways to calculate readmission rates. While the method used here misses readmissions that occur during the same calendar year, it does detect readmissions within a specific time window, thus allowing comparisons among health plans. A methodology allowing more complete capturing of readmissions is being developed and evaluated.

➤ Classify members according to their age at the time of the discharge date of the index episode.

Template Table 50: Readmission for Chemical Dependency: Medicaid, Commercial and Medicare Risk (reported separately)

Age	Sex	Hospitalized in Year Prior to Reporting Year	Readmitted within 90 Days of Prior Year's Index Discharge		Readmitted with 365 Days of Prior Year's Index Discharge	
			Number	Percent	Number	Percent
0-12	Male					
	Female					
	Total					
13-17	Male					
	Female					
	Total					
18-64	Male					
	Female					
	Total					
65+	Male					
	Female					
	Total					
Unknown	Male					
	Female					
	Total					
Total	Male					
	Female					
	Total					

OUTPATIENT DRUG UTILIZATION

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ***This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to Medicare risk population as well.***
- ***Age stratification is more detailed for children and for members age 65 and older, to account for the demographic characteristics of the Medicaid and Medicare risk populations.***

Description

This measure summarizes data on outpatient utilization of drug prescriptions (Total Cost of Prescriptions, Average Cost of Prescriptions per Member per Month, Total Number of Prescriptions and Average Number of Prescriptions per Member per Year) during the reporting year, stratified by age.

Specifications

Calculation:

Medicaid, Commercial and Medicare Risk: 5P-1a, 5P-1b, 5P-1c, 5P-1d, 5P-2a, 5P-2b and 5P-3 are constructed using Table 5P as a template.

Plans may define "prescription" as either:

One 30-day (or less) supply of pharmaceuticals.

OR

One supply of pharmaceuticals for which the plan accepts a copayment.

Specify which method is used.

Total cost of prescriptions is defined as any copayments and/or deductibles made by a member, plus the total cost of ingredients and dispensing fee, where the total cost of ingredients excludes any discounts that the health plan negotiates.

Formulas:

- Average total cost of prescriptions per member per month = ([Total cost to health plan for drug ingredients – discounts] + dispensing fees + member copayments and deductibles)/member months for members with a drug benefit.
- Annual total number of prescriptions per member per year = (Total number of prescriptions/member months for members with a drug benefit) x 12 months.

Notes

- Member months in the accompanying table should include only those members with a pharmacy benefit.
- Copayment may equal zero.
- Count each refill as a separate prescription.
- Count rebates the pharmacy receives after sales as "discounts."
- Supplies (e.g., syringes) do not count towards this measure.
- Base the cost and number of prescriptions in the numerators only on prescriptions dispensed to members with a pharmacy benefit.
- Member copayments and deductibles are included in the cost calculation because employers and states are interested in knowing the total cost of prescriptions, not the cost to the health plan.
- We expect future versions of HEDIS to move toward the 30-day supply method. Plans that use mail-order pharmaceuticals will need to develop record-keeping systems consistent with this approach (i.e., the 30-day supply as the unit of analysis).

Template Table 5P: Outpatient Drug Utilization: Medicaid, Commercial and Medicare Risk (reported separately)

Age	Member Months
0-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Specification Documentation: Prescription is defined as (check one)

One 30-day (or less) supply of pharmaceuticals

One supply of pharmaceuticals for which the health plan accepts a copayment

Age	Total Cost of Prescriptions	Average Cost of Prescriptions per Member per Month	Total Number of Prescriptions	Average Number of Prescriptions per Member per Year
0-9				
10-19				
20-44				
45-64				
65-74				
75-84				
85+				
Unknown				
Total				

NEW MEMBER ORIENTATION/EDUCATION

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ***This measure, from Medicaid HEDIS, now applies to the commercial and Medicare populations as well.***
- ***A question on educational efforts targeted at particular populations has been added.***

Description

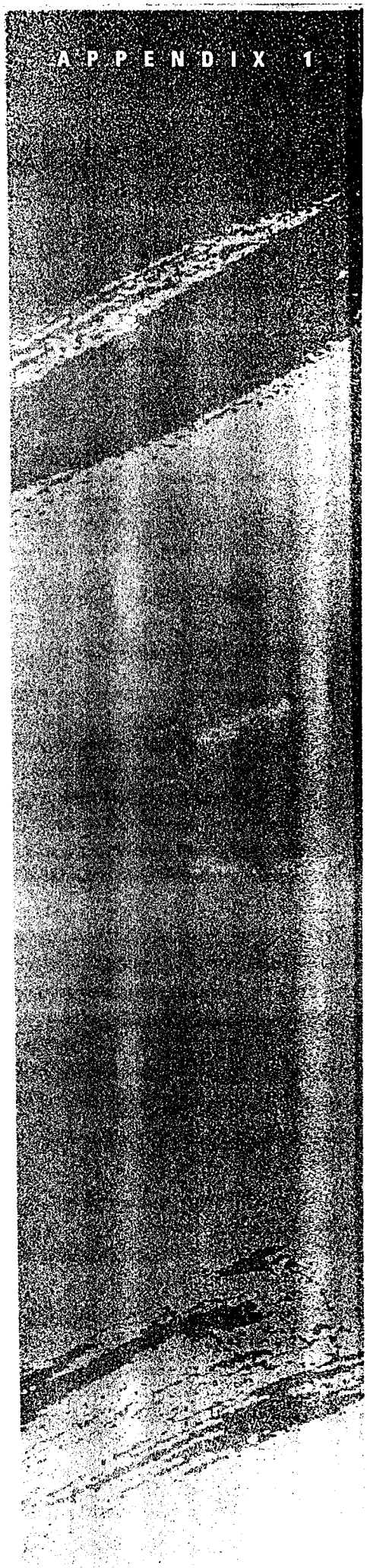
This measure solicits a narrative description of plan efforts to orient and educate new members (Medicaid, commercial and Medicare risk populations). It is reported separately for each population.

Specification

In 250 words or less (per population), describe:

- procedures used to educate and orient new members on methods for appropriately accessing and using plan services and
- any special targeted efforts to educate and orient particular populations (Medicaid, commercial and/or Medicare risk).

APPENDIX 1



GUIDELINES

for Sampling and Calculations

SAMPLE SIZE

New Measures or New Populations

In general, for new measures or payer populations for which a measure is new, plans should use Table I to determine the appropriate sample size. A plan collecting HEDIS data for the first time must use Table I.

Existing Measures

In general, if a plan has calculated a particular measure in the previous year, and is planning to use the hybrid method, it should use the rate derived from administrative data for the current year or the previous year's reported rate (whichever most accurately reflects the expected performance) along with Table II to determine the appropriate sample size. Do NOT use Table I in this case. As a plan's rate improves, the sample size will decrease. Because of the changes in specifications from HEDIS 2.5 to HEDIS 3.0, the previous year's rate cannot be used in 1997 for measures brought forward from HEDIS 2.5 to HEDIS 3.0.

In some cases, plans will not be able to achieve the desired sample size. For example, a plan may have very few inpatient admissions for a measure such as Follow-Up After Hospitalization for Mental Illness. When the sample size is between 30 and 100, the measure will have little power to detect differences between plans that are smaller than 20 percentage points. Because such measures are still very valuable, however, plans should collect and report them along with 95% confidence intervals (See Calculation of the 95% Confidence Interval in this Section for instructions). For sample sizes less than 30, the requirements for reporting vary by payer. Refer to Guidelines for Data Collection and Reporting for details.

Table 1: Sample Sizes for First-Year Reporting

Measure	Medicaid	Commercial	Medicare Risk
Effectiveness of Care			
Childhood Immunization Status	411	411	N/A
Adolescent Immunization Status	411	411	N/A
Advising Smokers to Quit	1860	1860	1860
Flu Shots for Older Adults	N/A [2]	N/A [2]	To be provided [1]
Breast Cancer Screening	411	411	411
Cervical Cancer Screening	411	411	N/A
Prenatal Care in the First Trimester	411	411	N/A
Low Birth-Weight Babies	N/A [3]	N/A [3]	N/A [3]
Check-Ups After Delivery	411	411	N/A
Treating Children's Ear Infections	411	411	N/A
Beta Blocker Treatment After a Heart Attack	411	411	411
Eye Exams for People with Diabetes	411	411	411
The Health of Seniors	N/A [2]	N/A [2]	1,000
Follow-Up After Hospitalization for Mental Illness	411	411	411
Access/Availability of Care			
Initiation of Prenatal Care	411	411	N/A
Annual Dental Visit	411	N/A	N/A
Satisfaction with the Experience of Care			
Member Satisfaction Survey	N/A	1860	N/A
Use of Services			
Well-Child Visits in the First 15 Months of Life	411	411	N/A
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	411	411	N/A
Adolescent Well-Care Visit	411	411	N/A
Frequency of Ongoing Prenatal Care	411	N/A	N/A

1. This measure will be collected usig the CAHPS Survey. Sample size will be provided in the CAHPS manual.
2. The number of individuals age 65 and over whose primary coverage is commercial or Medicaid is extremely small. It is not feasible to collect this measure for those populations.
3. Administrative data only — no sample size required.

Table II: Sample Sizes for Subsequent Years Reporting

For subsequent years, plans may use a rate calculated from administrative data in the current year or last year's reported rate, whichever is likely to be closest to current performance, to determine the sample size.

If Administrative Rate is	Sample Size is	If Administrative Rate is	Sample Size is
50% or less	411	73%	328
51%	411	74%	321
52%	410	75%	313
53%	410	76%	305
54%	409	77%	296
55%	407	78%	288
56%	405	79%	279
57%	403	80%	270
58%	401	81%	260
59%	398	82%	250
60%	395	83%	240
61%	392	84%	229
62%	388	85%	219
63%	384	86%	207
64%	380	87%	196
65%	376	88%	184
66%	371	89%	172
67%	366	90%	159
68%	360	91%	147
69%	354	92%	134
70%	348	93%	120
71%	342	94%	106
72%	335	95% or higher	100

STATISTICAL ASSUMPTIONS FOR SAMPLE SIZE

- Sample size is calculated assuming a two-tailed test of significance between two proportions (= 5%, 80% power, two-tailed test of significance). A normal approximation to the binomial with a continuity correction was employed in the sample size calculation. The worst-case assumption of a 50% expected value was assumed.
- The detectable difference for most measures is 10 percentage points. This was chosen because it is a big enough difference to be actionable, it is not unduly burdensome for data collection, and it is not so small as to be "swamped" by non-sampling error. The only exception is Advising Smokers to Quit, for which the difference is 20 percentage points. This is because there is likely to be a 20 percentage point difference between plans that have intervention programs and those that do not. Therefore, a 20 percentage point difference is meaningful for this measure.

SAMPLING METHODOLOGY

Plans could use many strategies to select samples of medical records. Acceptable methods for HEDIS 3.0 fall into two general classes:

- *Simple Random Sampling* — This strategy is assumed in the sample size calculations above. The simplest method for simple random sampling is to assign a uniform random number to each individual in an available eligible population and sort the available eligible population in ascending order by the random number. The sample is then selected from the top of the list.
- *Complex Probability Sampling* — Properly applied, other techniques — stratified sampling, cluster sampling, and other complex probability approaches — can improve precision and increase sampling efficiency. If complex sampling methodologies are used, the estimated rate should be reported along with any information required to perform a valid test of significance between that rate and another plan's rate. The plan should also report the sample size (if different from the HEDIS recommendation) and document the method used in the calculation (including software used, if applicable). Health plans should consult a statistician before implementing a complex sampling methodology.

OVERSAMPLING AND SUBSTITUTION OF MEDICAL RECORDS

For measures where the hybrid method is used, the starting sample size should be higher than the designated sample size. This is because medical records must be substituted if the patient is found to be ineligible for the measure (e.g. a member is found to have been incorrectly identified as a diabetic through administrative data, or a member is contraindicated for the procedure being measured). To adjust for this, divide the sample size by the proportion of charts expected to be appropriate for review. For example, suppose 20% of charts are expected to be inappropriate for the measure. Thus, 80% should be appropriate. The final sample size = 411/80% = 514. A health plan may

choose not to increase the sample size. However, this may result in a reduction in the ability to detect a meaningful difference between plans. The recommended methodology for carrying out substitution is as follows:

- After selecting the sample of 411 and an appropriate oversample, leave the list in random order, and split the list into the primary list consisting of the first 411 members and an auxiliary list consisting of the oversampled members. Both lists should be in random order.
- Begin abstraction for members of the primary list. Upon finding that a member is ineligible for the measure, replace the member's chart with that of the first member in the auxiliary list.
- Continue abstraction, replacing each ineligible member with the next consecutive member of the auxiliary list.

POPULATION DEFINITION

In some cases, plans may not have enough eligible members in their entire enrollment to meet the sample size requirements. In these cases, plans must use their entire eligible enrollment and report the data with 95% confidence intervals. Why should 95% confidence intervals be used when the entire enrollment is included? The answer is in how the population is defined, which is determined by how the data are used. When data are used for decision-making, by definition, inference is made either to a future expected performance or to a group of potential members. In either case, the user is interested in the "process of care," which goes beyond the performance of the plan in a single year for a static population. Thus, it is appropriate to consider the entire available enrollment of a plan as a sample from the universe of all years or all populations from which such a sample could be drawn.

FINITE POPULATION CORRECTION

When calculating the sample size using the hybrid method, plans naturally consider applying a finite population correction (FPC) factor in sample size calculation to reduce the sample size. Given that HEDIS 3.0 views the plan's enrollment as a sample (see discussion above) and the use of the FPC decreases the power to detect differences, it is not appropriate to use the FPC for public reporting of HEDIS measures.

CALCULATION OF THE 95% CONFIDENCE INTERVAL

The formula for calculating the 95% confidence interval is:

$$lower = p - 1.96\sqrt{\frac{p(1-p)}{n}} - \frac{1}{2n}$$

$$upper = p - 1.96\sqrt{\frac{p(1-p)}{n}} + \frac{1}{2n}$$

where p = the plan's rate, n = the sample size.

For example, suppose a plan has a sample size of 411 eligible women for its Breast Cancer Screening rate. Of these, 300 received a mammogram during the year. The calculation would proceed as follows:

$$p = \frac{300}{411} = 73\%$$

$$lower = .73 - 1.96\sqrt{\frac{.73(1-.73)}{411} - \frac{1}{822}} = 68.6\%$$

$$upper = .73 - 1.96\sqrt{\frac{.73(1-.73)}{411} - \frac{1}{822}} = 77.4\%$$

Thus, the user can be 95% certain that the plan's true mammography rate is between 68.6% and 77.4%

Notes

- For rates near 0%, the lower limit may be negative. If this occurs, replace the lower limit with 0%.
- For rates near 100%, the upper limit may exceed 100%. If this occurs, replace the upper limit with 100%.

There are more complex confidence interval calculations that have better properties at extreme values. This formula is provided because it performs adequately over a wide range of percentages, and is computationally simple. Quality Compass will likely use a more complex formula; confidence intervals calculated by Quality Compass may not exactly match plan-reported intervals, but should be close over a wide range of values.

References

- *Statistical Methods for Rates and Proportions 2nd ed.*, Joseph L. Fleiss, John Wiley & Sons, Inc., New York, pp. 38-42
- *Clinical Practice Guideline Number 18: Smoking Cessation*, AHCPR Publication number 96-0692, April, 1996
- On the Interpretation of Censuses as Samples, W. E. Deming (1941) Journal of the American Statistical Association. Volume 36, pp. 45-49.

National Committee
for Quality Assurance

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036

Main: 202/955-3500
FAX: 202/955-3599
http://www.ncqa.org

NCQA

SUMMARY OF CHANGES TO THE HEDIS 3.0 DRAFT

On September 25 and 26, 1996, NCQA's Committee on Performance Measurement met to consider thousands of comments received following the July 1996 public release of the draft version of HEDIS 3.0, and to make final changes to the measurement set. The following pages list the highlights of those discussions, and the rationale for the changes. Part I contains changes and clarifications to data collection and reporting guidelines, and Part II contains changes to the measures themselves, which are organized by domain.

One fundamental clarification involves the time-frame over which the transition to HEDIS 3.0 from earlier versions of HEDIS reporting will be expected. In short, for the Effectiveness of Care, Health Plan Stability, Cost of Care, Informed Health Care Choices and Health Plan Descriptive Information domains, all HEDIS 3.0 measures are required for all populations to which they are applicable in **Reporting Year 1996** (data to be reported in 1997.

For the Use of Services and Access/Availability of Care domains, measures that originated in HEDIS 2.5 will be upgraded to 3.0 specifications and applicable to the appropriate populations in **Reporting Year 1996**, and measures that originated in Medicaid HEDIS will be upgraded to HEDIS 3.0 specifications, but applicable only to the Medicaid populations until **Reporting Year 1997** (data reported in 1998). Health plans should be prepared to report their HEDIS information to external requesters by June 1, 1997.

This transition timeline both allows health plans to make the necessary adjustments for collecting data, and provides the significant advantages of the improved measures in HEDIS 3.0

PART I: CHANGES TO GENERAL GUIDELINES FOR DATA COLLECTION AND REPORTING

- **Change:** A separate HEDIS report should be produced for each state in which the health plan has a Medicaid contract. (The draft instructed plans to prepare a single report for all of its Medicaid enrollees.)
- **Rationale:** State Medicaid agencies reported that HEDIS information would not be useful unless it was prepared for each state.

- **Change:** Medicare HMO members under age 65 should be included in a plan's Medicare HEDIS report. (The draft excluded these members.)
- **Rationale:** Only about 4 percent of Medicare managed care enrollees are under 65, but this change makes HEDIS a more inclusive document.

- **Change:** Members who are eligible for both Medicaid and Medicare should be included in **both** HEDIS reports. (The draft instructed that plans include these members in one or the other.)

- **Rationale:** This change ensures that all Medicaid enrollees are accounted for, whether or not they are dually eligible.

- **Change:** The following passage from the draft has been deleted: "If data is not 95% complete, plans should be prepared to submit again six months after the close of the reporting year if requested."
- **Rationale:** Plans and purchasers will negotiate time-frame arrangements that work best for them.

- **Change:** Information obtained from medical records must come from an "author-identified" note. (The draft required that a provider sign or initial such notes.)
- **Rationale:** This change makes HEDIS consistent with NCQA Accreditation standards. Over the next 12 months, the CPM will develop guidelines and audit standards that will allow health plans to use letters of attestation from providers in place of medical record review, thereby easing administrative burden on plans and providers.

PART II: CHANGES TO THE MEASURES

EFFECTIVENESS OF CARE MEASURES

- **Change:** Movement of the Flu Shots for High-Risk Adults measure to the Testing Set.
- **Rationale:** The CPM decided to move this measure to the Testing Set to evaluate various operational issues, including how to consistently identify the high-risk population.

- **Change:** Change in the methodology for the Flu Shots for Older Adults measure.
- **Rationale:** The CPM decided that health plans should collect the information for this measure using patient survey data, rather than administrative or medical records. Flu shots are often provided outside of the health plan, and relying on plan records may lead to underreporting.

- **Change:** Extend the time frame associated with the Beta Blocker Treatment After A Heart Attack measure to seven days after discharge (the draft specified two days), and 30 days before hospitalization.
- **Rationale:** A sample of beta blockers may be rendered in the hospital prior to discharge, or patients may already be taking beta blockers prior to the heart attack. Allowing five extra days to fill the prescription will give health plans an additional opportunity to use administrative data (i.e., pharmacy data) to collect this measure.

- **Change:** Change in the specifications for the Treating Children's Ear Infections measure.

- **Rationale:** This measure, which reports how many children receive appropriate antibiotic treatment for ear infections, was modified so that rates will resemble those of other Effectiveness of Care measures. Specifically, the numerator was modified to capture members who receive an antibiotic other than a preferred antibiotic, in order to recognize cases in which children were appropriately not prescribed any antibiotic.

- **Change:** Movement of the Use of Appropriate Medications for People With Asthma measure to the Testing Set.
- **Rationale:** Public comment revealed methodological limitations and questions about the clinical value and appropriateness of this measure for assessing the quality of care delivered to asthmatics. For example, some commenters stated that there was no evidence that inhaled corticosteroids or cromolyn – the medications reported in the measure -- are effective forms of treatment for *all* asthmatics. Given the high prevalence of the disease, however, the CPM intends to include, next year, one or more asthma related measures currently being tested under a joint project between NCQA and the Robert Wood Johnson Foundation.

- **Change:** Maintenance of the annual screening interval for Diabetic Eye Exams
- **Rationale:** Appropriate retinal screening intervals for people with diabetes are currently the subject of some debate. While the draft of HEDIS 3.0 proposed moving from a one-year to a two-year screening interval, evolving evidence suggests that a two-year screening interval may be inappropriate for a significant number of diabetics. The CPM decided that it was preferable to remain with the measure as it has been reported over the past three years, to allow the further evolution of evidence in support of a change. The CPM anticipates substantial improvement in this measure over time.

- **Change:** Standardization of Medical Advice to Quit Smoking
- **Rationale:** The CPM decided to require that questions regarding advice to stop smoking be added to the Annual Member Health Care Survey, in order to achieve standardized reporting.

- **Change:** Revision in sampling for the Health of Seniors measure.
- **Rationale:** There was concern that over time the replenishment strategy employed in the draft would lead to a biased cohort -- a sample that no longer provides meaningful information on plan performance. An alternate approach was accepted by the CPM, whereby plans will establish a new cohort of 1,000 members to survey every year.

ACCESS/AVAILABILITY OF CARE MEASURES

- **Change:** Deletion of Appointment Access and Telephone Access measures.
- **Rationale:** The CPM concluded that the lack of standard methodologies for determining actual waiting times imposes limitations on inter-plan comparisons, and

the questions in the Annual Member Health Care Survey that address patient satisfaction with appointment and telephone access provide better information. The CPM also decided to give the development of additional measures in these areas high priority.

- **Change:** Deferral (for one year) of the Low Birth Weight Deliveries at Facilities for High Risk Deliveries and Neonates of High Risk measure.
- **Rationale:** The inclusion of this measure in the set required for the 1996 reporting year was an oversight in the draft. The measure uses the same methodology for identifying low birth weight babies as the Low Birth Weight Babies measure in the Effectiveness of Care domain. Both are deferred until the 1997-reporting year, in anticipation of the development of improved methodology.

HEALTH PLAN STABILITY MEASURES

- **Change:** Disenrollment information applicable to commercial and Medicare risk populations only.
- **Rationale:** Since most Medicaid beneficiaries leave health plans because they lose eligibility (e.g., in many states, pregnant women lose Medicaid eligibility 60 days after delivery), aggregate disenrollment rates provide no useful information for Medicaid agencies.

USE OF SERVICES MEASURES

- **Change:** Age stratification for persons 65 and older modified.
- **Rationale:** Age stratification in most use of services tables will be : 65-74; 75-84; and 85+, to account for the needs of the users of the information. (The draft specified age strata of 65-79, and 80+.)

- **Change:** Frequency of Selected Procedures for Medicare populations.
- **Rationale:** Based on updated information from the U.S. Health Care Financing Administration, the following procedures will be measured for Medicare enrollees: Coronary Artery Bypass Graft (CABG); Angioplasty; Prostatectomy; Cholecystectomy; Reduction of Fracture of Femur; Total Knee Replacement; Partial Excision of Large Intestine; Carotid Endarterectomy; Total Hip Replacement; and Hysterectomy. (The draft specified CABG, Angioplasty, Cardiac Catheterization; Cholecystectomy; and Prostatectomy.)

- **Change:** Births and Average Length of Stay, Newborn
- **Rationale:** The table in this measure was modified to facilitate adding newborn utilization rates to utilization rates reported in the table on Inpatient Utilization -Acute Care.

- **Change:** Continuous enrollment criterion in the tables "Mental Health Utilization. Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Service," and Chemical Dependency Utilization. Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Service."
- **Rationale:** The continuous enrollment criterion specified for these tables in the draft was dropped because of concerns about excluding a significant number of Medicaid enrollees. HEDIS 2.5 specifications for these tables will be retained for 1996 reporting.

National Committee
for Quality Assurance

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036

Main: 202/955-3500
FAX: 202/955-3599
http://www.ncqa.org

NCQA

Subsequent to the release of the Advance Copy of *HEDIS® 3.0, Volume II: Technical Specifications* in October 1996, NCQA learned from those implementing the new measurement specifications of several errors, inconsistencies and/or areas needing clarification. In order to share this information, already provided to individual organizations, with everyone who uses HEDIS 3.0, we made the necessary modifications to the final HEDIS 3.0 technical specifications. The following pages list each change from the Advance Copy to the final *HEDIS 3.0, Volume 2*. ***All changes documented in the attached pages are reflected in HEDIS 3.0, Volume 2.***

The changes are listed in order by domain, and within each domain by measure. Each change is listed along with the page number and location reference in the Advance Copy and corresponding page number and location reference in the final *HEDIS 3.0, Volume 2*. When appropriate, we also included the reason for the change in brackets [ ]. ***The changes do not significantly alter the specifications and should require minor, or no, programming changes; the majority of changes are clarifications to the specifications.***

Note: In November 1996, NCQA released the replacement technical specifications for the Member Satisfaction Survey measure. The revised specifications for this measure, contained in the Satisfaction with the Experience of Care domain, are <u>not</u> included in the following pages. The final *HEDIS 3.0, Volume 2* contains the updated specifications for this measure.

Note: For organizations that ordered the complete set of HEDIS 3.0 (i.e., Volumes 1-4), Volume 4, *A Road Map for Information Systems*, will be released this spring.

For assistance with interpreting the HEDIS 3.0 Reporting Set measurement specifications, please call NCQA, HEDIS Technical Support Line at 202-955-1737.

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
GUIDELINES FOR DATA COLLECTION AND REPORTING					
	1	Summary of Changes...	Information obtained from the medical record must come from an author-identified note. Members who switch from a plan's HMO product to its POS product or vice versa during a particular measure's continuous enrollment period may now be considered continuously enrolled for the reporting of that measure.	1	Information obtained from the medical record must come from an author-identified note, **which allows for handwritten, stamped or electronic identification.** Members who switch from a plan's HMO product to its POS product or vice versa during a particular measure's continuous enrollment period **should** now be considered continuously enrolled for the reporting of that measure.
	2	How many HEDIS Reports...	"Commercial members" are those...For the commercial population, report data for different product types separately.	2	"Commercial members" are those...For the commercial population, report data for different product types separately **(i.e., draw a separate sample for each product type).**
	6	Specific Guidelines...	A health plan is ultimately responsible...An author-identified note in the medical record indicating the date the procedure was performed, the place of the service, and the result (when applicable), or a consultation, lab or imaging report supports inclusion in the numerator.	6	A health plan is ultimately responsible...**When reviewing the medical record,** an author-identified note **(i.e., includes handwritten, stamped, or electronic initials/signature)** in the medical record indicating the date the procedure was performed, the place of the service, and the result (when applicable), or a consultation, lab or imaging report supports inclusion in the numerator
	9-10	Specific Guidelines... Obtaining Data from the Medical Record	For information obtained from patient history, HEDIS will allow the health plan to count the procedure if the medical record contains the following information: an author-identified note indicating the date the service was rendered, the place of the service, and the result (when applicable) or a consultation, lab or imaging report. Entries made in the medical record at the time the service was provided must include author identification, the date, and the result (when applicable). All medical record entries must be made and all service(s) must be rendered by the deadline for delivery ...	9	For information obtained from patient history,...**Medical records transferred from the member's previous provider must include a note from the provider to whom they were transferred indicating that he or she reviewed them.** Entries made in the medical record at the time the service was provided must include author identification, the date, and the result (when applicable) or **a consultation, lab or imaging report.** All medical record entries must be made, **all transferred records must be reviewed,** and all service(s) must be rendered by the deadline for delivery...

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
GUIDELINES FOR DATA COLLECTION AND REPORTING					
		Important Information on HEDIS 3.0 Implementation for Reporting Years 1996-1997		15-18	**Pages 15-18 have been incorporated into the document; they were previously released with the Advance Copy HEDIS 3.0 as an insert.**
DOMAIN: EFFECTIVENESS OF CARE					
Childhood Immunization Status	16	Description	The percentage...(including members who have had no more than one break in enrollment of up to 45 days during the reporting year)...	19	The percentage...(including members who have had no more than one break in enrollment of up to 45 days **during the 12 months immediately preceding their second birthday**)...
	16	Description	• Four DTP or DTaP vaccinations (or an initial DTP followed by at least three DTP and/or DT) by the second birthday...	19	• Four DTP or DTaP vaccinations (or an initial DTP **or DTaP** followed by at least three DTP, **DTaP** and/or DT) by the second birthday. [To reflect updated immunization schedule; DTaP is allowed for any of the four DTP vaccines.]
	17	Administrative Data Spec - Denominator	Two separate denominators, one for each of the two populations, are derived using all enrolled children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled for the 12 months immediately preceding their second birthday. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure	19-20	Two separate denominators, one for each of the two populations, are derived using all enrolled children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled for the 12 months immediately preceding their second birthday **and who were not contraindicated for any of the specified antigens.** Members who have no more than one break in enrollment of up to 45 days during the **12 months preceding their second birthday** should be included in this measure.

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Childhood Immunization Status (cont'd)	17	Administrative Data Spec - Numerator	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP followed by at least three DTP and/or DT (CPT-4 code 90702)	20	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP **or DTaP** followed by at least three DTP, **DTaP** and/or DT (CPT-4 code 90702) [To reflect updated immunization schedule; DTaP is allowed for any of the four DTP vaccines.]
	18	Hybrid Method Spec - Denominator	Two separate denominators,...Eligible members include all children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday, and who were continuously enrolled for the 12 months immediately preceding their second birthday. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	20	Two separate denominators,...Eligible members include all children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday, and who were continuously enrolled for the 12 months immediately preceding their second birthday **and who were not contraindicated for any of the specified antigens.** Members who have had no more than one break in enrollment of up to 45 days during **the 12 months preceding their second birthday** should be included in this measure.
	18	Hybrid Method Spec - Numerator	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, or an initial DTP followed by at least three DTP and/or DT (CPT-4 code 90702).	21	At least four DTP or DTaP (CPT-4 code 90700 or 90701 or 90711 or 90720 or 90721) with different dates of service by the child's second birthday, **or** an initial DTP or **DTaP** followed by at least three DTP, **DTaP** and/or DT (CPT-4 code 90702). [To reflect updated immunization schedule; DTaP is allowed for any of the four DTP vaccines.]

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Childhood Immunization Status (cont'd)	18-19	Hybrid Method Spec - Numerator	Note: For immunization information...Add records transferred from a previous health care provider or agency without a note that the responsible authorized health care provider or agency reviewed them.	21	For immunization information...Add records transferred from a previous health care provider or agency without a note that the **authorized health care provider, to whom the records were transferred, has reviewed them.**
Adolescent Immunization Status	22	Hybrid Method Spec - Denominator	Two separate denominators,...Eligible members include, respectively, Medicaid enrolled adolescents and commercially enrolled adolescents who turned 13 years old during the reporting year, who were members of the plan as of their 13th birthday, and who were continuously enrolled for 12 months immediately preceding their 13th birthday.	24	Two separate denominators,...Eligible members include, respectively, Medicaid enrolled adolescents and commercially enrolled adolescents who turned 13 years old during the reporting year, who were members of the plan as of their 13th birthday, who were continuously enrolled for 12 months immediately preceding their 13th birthday **and who were not contraindicated for MMR.**
	22-23	Hybrid Method Spec - Numerator	Note: For immunization information...Records transferred from a previous health care provider or agency without a note that the responsible authorized health care provider or agency reviewed them.	24	Note: For immunization information...Records transferred from a previous health care provider or agency without a note that the **authorized health care provider, to whom the records were transferred, has reviewed them.**
Advising Smokers to Quit	25	Description	Among Medicaid, commercial and Medicare risk enrolled adults age 21 and older as of the December 31 of the reporting year...	26	Among Medicaid, commercial and Medicare risk enrolled adults age **18** years and older as of December 31 of the reporting year... [To be consistent with the Member Satisfaction Survey measure]
	25	Specifications - Calculation	This specification uses membership data to identify adults age 21 and older and survey data to identify individuals who had one (or more) visits with a plan provider...	26	This specification uses membership data to identify adults age **18** years and older and survey data to identify individuals who had one (or more) visits with a plan provider...

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Advising Smokers to Quit (con't)	25	Specifications - Denominator	The denominator for this...First, three separate denominators, one for each of the three required calculations, are derived using random samples of Medicaid, commercial and Medicare risk enrolled adults aged 21 and older as of December 31 of the reporting year....	26	The denominator for this...First, three separate denominators, one for each of the three required calculations, are derived using random samples of Medicaid, commercial and Medicare risk enrolled adults age **18** years and older as of December 31 of the reporting year...
Flu Shots For Older Adults	30	Notes	6) Plans may identify...Individuals residing in hospice care (UB-92 "type of Bill" code: 81X or 82X; UB-92 "Revenue" code: 115, 125, 135, 145, 155, 650 or 659).	29	Plans may identify...Individuals residing in hospice care (UB-92 "type of Bill' code: 81X or 82X; UB-92 "Revenue" code: 115, 125, 135, 145, 155, 650, **651, 652, 655, 656, 657** or 659). [Added other relevant codes]
Breast Cancer Screening	31	Administrative Data Spec - Denominator	Three separate denominators, one for each of the three required calculations, are derived using all enrolled women age 52 through 69 years old as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year.	30	Three separate denominators, one for each of the three required calculations, are derived using all enrolled women age 52 through 69 years old as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year **and who were not identified as having had a radical bilateral mastectomy.**
	32	Hybrid Method Spec - Denominator	Eligible members include Medicaid enrolled women or commercially enrolled women or Medicare risk enrolled age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year.	31	Eligible members include Medicaid enrolled women or commercially enrolled women or Medicare risk enrolled age 52 through 69 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year and the preceding year **and who were not identified as having had a radical bilateral mastectomy.**

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Breast Cancer Screening (con't)	33	Table 1C - Exclusionary Codes	19240-50 19200-50 19220-50	31	19240-50 or **19240 and 09950** 19200-50 or **19200 and 09950** 19220-50 or **19220 and 09950** [Added other relevant codes]
Cervical Cancer Screening	34	Administrative Data Spec - Denominator	Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year.	32	Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year **and who were not identified as having had a hysterectomy with no residual cervix.**
	35	Hybrid Method Spec - Denominator	Two separate denominators...Eligible members include all women age 21 through 64 years as of December 31 of the reporting year, who were members of the plans as of December 31 of the reporting year, and who were continuously enrolled during the reporting year.	33	Two separate denominators...Eligible members include all women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, and who were continuously enrolled during the reporting year **and who were not identified as having had a hysterectomy with no residual cervix.**
Prenatal Care in the First Trimester	37	Description	The percentage of Medicaid and commercially enrolled women with a live birth during the reporting period, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	34	The percentage of Medicaid and commercially enrolled women who delivered live birth during the reporting year, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal care visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks **prior to delivery** should be included in this measure.

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Prenatal Care in the First Trimester (cont'd)	37	Administrative Data Spec - Denominator	Two separate denominators, one for each of the two required calculations, are derived using all members who had (a) live birth(s) during the reporting period and who were enrolled in the plan for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	34	Two separate denominators, one for each of the two required calculations, are derived using all women who delivered (a) live birth(s) during the reporting year and who were **continuously** enrolled in the plan for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the **44 weeks prior to delivery** should be included in this measure.
	39	Hybrid Method Spec - Denominator	Eligible members include all women who had (a) live birth(s) during the reporting period, and who were continuously enrolled for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure.	35	Eligible members include all women who delivered (a) live birth(s) during the reporting year, and who were continuously enrolled for 44 weeks prior to delivery. Members who have had no more than one break in enrollment of up to 45 days during the **44 weeks prior to delivery** should be included in this measure.
	43	Table 1E - Decision Rule 2	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 with either ICD-9 -CM = (640.0x-648.9x or 651.0x - 659.9x) where x (5th digit)=3 OR ICD-9-CM = V22.0-V23.9 or V28.x *or* CPT-4 = 80055 alone or 90090 alone or 86762 with 86900 or 86901; OR CPT-4 = 76805, 76815, or 76816	39	CPT-4 = 99201-99205, 99211-99215; or Revenue code 514 ***with either*** **CPT-4 = 80055 alone or 80090 alone or 86762 with 86900 or 86901;** ***or*** **CPT-4 = 76805, 76815, or 76816** ***OR*** **ICD-9 -CM = (640.0x-648.9x or 651.0x - 659.9x) where x (5th digit)=3** ***or*** **ICD-9-CM = V22.0-V23.9 or V28.x** **[No codes were deleted or added. Order of codes was reversed to align with the Marker Event Description]**

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Low Birth-Weight Babies	49	Table 1F	1st row (count as one newborn)	43	**New code added--first line of the table - V35.xx**
Treating Children's Ear Infections	55	Description	Health plans should only count the first episode of acute otitis media occurring during the reporting year, and no child should be counted more than once in this measure.	48	Health plans should only count the first **uncomplicated** episode of acute otitis media occurring during the reporting year, and no child should be counted more than once in this measure.
	59	Table 1G	Other bacterial infection - 040.x, 041.xx	51	Other Bacterial infection - **040.xx**, 041.xx [Code correction]
Beta Blocker Treatment After a Heart Attack	64	Notes	3. Any patient with ICD-9-CM diagnosis code 410.x2 (AMI, subsequent episode of care) should be excluded from this measure.	55	Any **episode** with ICD-9 CM diagnosis code 410.x2 (AMI, subsequent episode of care) should be excluded from this measure.
Eye Exams for People with Diabetes	69	Notes		60	**Note: Plans may exclude members who, through medical record review, are identified as not being diabetic.** **[New note added]**
Follow-up After Hospitalization for Mental Illness	75	Administrative Data Spec - Denominator	If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the rate. However, if a discharge is followed by a readmission for any selected mental health-disorder within the 30-day follow-up period, only the readmission discharge should be counted.	65	If a member has more than one discharge during the 330-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the rate. However, if a discharge **for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis** within the 30-day follow-up period, only the readmission discharge should be counted. **Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.**

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: EFFECTIVENESS OF CARE					
Follow-up After Hospitalization for Mental Illness (con't)	77	Hybrid Method Spec - Denominator	If a member has more than one discharge during the 30-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the sampling frame. However, if a discharge is followed by a readmission for any mental health disorder within the 30-day follow-up period, only the readmission discharge should be counted.	67	If a member has more than one discharge during the **330**-day period with a diagnosis of one of the selected mental health disorders listed above, that member may be reflected more than once in the sampling frame. However, if a discharge **for one of the selected mental health disorders is followed by a readmission for any mental health or chemical dependency diagnosis** within the 30-day follow-up period, only the readmission discharge should be counted. **Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.**
	78	Notes	2. If a Medicaid, commercial or Medicare risk member identified in the denominator of this measure is rehospitalized for any mental health or chemical dependency diagnosis within 30 days of discharge for one of the selected mental health disorder hospitalizations, only the rehospitalization should be counted in this measure. Although the rehospitalization might not be for one of the selected mental health disorders, it most likely is for a related condition.	67	**This note was removed; it was added to the denominator specifications.**
	78	Notes	3. Plans may exclude from the denominator those individuals who have been discharged directly from the hospital to another inpatient setting (e.g., nursing facility, residential treatment facility).	67	Plans may exclude from the denominator those individuals who have been discharged directly from the hospital to **a non-acute** setting (e.g., nursing facility, residential treatment facility).

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: ACCESS/AVAILABILITY OF CARE					
Availability of Mental Health/ Chemical Dependency Providers	91	Specifications - Definition	An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has master's degree in social work or is licensed to practice as a social worker, if required by the state of practice.	77	An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has master's degree in social work and is licensed to practice as a social worker, if required by the state of practice.
DOMAIN: USE OF SERVICES					
Frequency of Ongoing Prenatal Care	144	Description	The percentage of pregnant Medicaid-enrolled women who received <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the expected number of prenatal care visits, adjusted for gestational age and the month prenatal care begin.	125	The percentage of pregnant Medicaid-enrolled women who received **<21%**, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the expected number of prenatal care visits, adjusted gestational age and the month prenatal care begin.
	144	Administrative Data Spec - Calculation	For each woman who had ...4) report an unduplicated count of the number of women who had <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.	125	For each woman who had...4) report an unduplicated count of the number of women who had **<21%**, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.
	146	Administrative Data Spec - Numerator	The number of women in the denominator who had an unduplicated count of <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.	126	The number of women in the denominator who had an unduplicated count of **<21%**, 21% through 40%, 41% through 60%, 61% through 80% or ≥ 81% of the number of expected visits, adjusted for the month prenatal care began and gestational age.

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996
TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: USE OF SERVICES					
Frequency of Ongoing Prenatal Care (con't)	146-147	Administrative Data Spec - Numerator	For each woman included in the denominator...8) Report each woman in the appropriate category: <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits.	127	For each woman included in the denominator.. Report each woman in the appropriate category: **<21%**, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits.
	148	Hybrid Method Spec - Numerator	The number of enrolled women in the sample who had an unduplicated count of <20%, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits, adjusted for the month prenatal care began while enrolled in the plan and gestational age.	128	The number of enrolled women in the sample who had an unduplicated count of **<21%**, 21% through 40%, 41% through 60%, 61% through 80% or ≥81% of the number of expected visits, adjusted for the month prenatal care began while enrolled in the plan and gestational age.
Frequency of Selected Procedures	169	Table 5B: Codes	These classification codes are used to identify the procedures reported in Tables 5C-1a-d, 5C-2a-b, 5C-3	146	Removed the "-d" to state 5C-1a. Measure should be reported for "Total Medicaid Only.
Ambulatory Care	191	Observation Room Stays	UB-92 Revenue code (Form Locator 42): 76.2 (Observation Room)	166	UB-92 Revenue code (Form Locator 42): **762** (Observation Room)
	189	Ambulatory Surgery/ Procedures	Instructions:....CPT-4 code: all Codes included in HCFA Ambulatory Surgical Center (ASC) payment listing,... Note: The HCFA ASC payment listing is available on diskette for $75 through the Bureau of Data Management and Strategy at (410) 786-3689. The listing is also available in hard copy for $20	165	Instructions...CPT-4 code: All codes included in the HCFA Ambulatory Surgical Center (ASC) **Base Eligibility File**... Note: The HCFA ASC **Base Eligibility File** is available through the Bureau of Data Management and Strategy at (410) 786-**3691.** [The listing is no longer available in hard copy.]
	191	Observation Room Stays - Notes	2. UB 82/92 revenue codes 76.0 and 76.9.	167	UB-92 revenue codes **760** and **769**.

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996 TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
DOMAIN: COST OF CARE					
Rate Trends	244	Table 6B - Rate Trend Assumptions	Please provided the percent change in prospective rate trend assumptions used to calculate the PMPM premium rates for the plan's commercial book of business for each year indicated.	212	Please provide the percent change in prospective rate trend assumptions used to calculate PMPM premium rates for the plan's **Medicaid, commercial, or Medicare risk** book of business for each year indicated.
DOMAIN: HEALTH PLAN DESCRIPTIVE INFORMATION					
Provider Compensation	260	Definition of mental health providers	Mental health providers include psychiatrists, psychologists, social workers, psychiatric nurse specialists, marriage and family therapists and providers with a Specialty Certification in Mental Health Counseling from the National Board Certified Counselors (NBCC).	227	Mental health providers include psychiatrists, psychologists, social workers, psychiatric nurse specialists, marriage and family therapists and **professional counselors.**
HEDIS 3.0 MEASURES GRID					
	330	Effectiveness of Care	Flu Shots for Older Adults indicated reporting for all populations (Medicaid, commercial, Medicare risk).		**It is only applicable to Medicare population.**
	331	Health Plan Stability	Disenrollment indicated reporting for all populations (Medicaid, commercial, Medicare risk)		**It is only applicable to Medicare and commercial populations.**
	331	Health Plan Stability	Physician Turnover	298	Measure called Provider Turnover
	331	Health Plan Stability	Performance Indicators	298	Measure called Indicators of Financial Stability
	332	Use of Services	Discharge and Average Length of Stay for Females in Maternity Care	299	Measure called Discharge and Average Length of Stay - Maternity Care
GUIDELINES FOR SAMPLING AND CALCULATIONS					
	308	Sample Size - New Measures or New Populations	In general, for new measures... A plan collecting HEDIS data for the first time must use Table I. Since all measure specifications have changed from HEDIS 2.5 to HEDIS 3.0, Table I must be used ...	271	In general, for new measures... A plan collecting HEDIS data for the first time must use Table I. **(Language was removed)**

CHANGES FROM THE ADVANCE COPY *HEDIS® 3.0, VOLUME II: TECHNICAL SPECIFICATIONS* - OCTOBER 1996 TO THE FINAL *HEDIS 3.0, VOLUME 2* - JANUARY 1997

Advance Copy Specifications - October 1996				Final Specifications - January 1997	
Measure	Page	Location	Old Language	Page	New Language
GUIDELINES FOR SAMPLING AND CALCULATIONS					
	308	Sample Size - Existing Measures	In general, if a plan has calculated...As a plan's rate improves, the sample size will decrease. Table II cannot be used in 1997 because of the changes in specifications from HEDIS 2.5 to HEDIS 3.0.	271	In general, if a plan has calculated...Because of the changes in specifications from HEDIS 2.5 to HEDIS 3.0, the previous year's rate cannot be used in 1997 for measures brought forward from HEDIS to HEDIS 3.0.
	309	Table I	Advising smokers to quit--Samples sizes for all populations to be provided	272	Advising smokers to quit - sample size provided for all populations.

National Committee
for Quality Assurance

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036

Main: 202/955-3500
FAX: 202/955-3599
http://www.ncqa.org

NCQA

The attached 'Correction Sheet for HEDIS® 3.0' documents errors contained in the final *HEDIS 3.0, Volume 2* and the corrected language. The domain, measure name, page number and description of the correction is documented on the following three pages. These corrections should be implemented for the HEDIS 3.0 1996 data collection period.

Note: The changes listed in the attached document are NOT reflected in the final *HEDIS 3.0, Volume 2*.

Correction Sheet for HEDIS 3.0 January 1997				
Domain	**Measure**	**Page Number, final *HEDIS® 3.0, Volume 2***	**Location**	**Correction (in Bold)**
Effectiveness of Care	Breast Cancer Screening	30	Administrative Data Spec - Numerator	ICD-9-CM code 174.xx should be **174.x**; there are no 5th digits within the 174 series
Effectiveness of Care	Check-ups After Delivery		Administrative Data Spec - Numerator	The number of women in the denominator for each of the two populations...A woman is considered to have had a postpartum visit if a submitted claim/encounter includes any of the following codes and has a date of service between the **date of delivery** and the 42nd day after the delivery.
Effectiveness of Care	Treating Children's Ear Infections	51	Table 1G--Rickettsioses & arthropod disease	ICD-9-CM code range 081.x1-083.x should be **081.x-083.x**
Effectiveness of Care	Treating Children's Ear Infections	52	Table 1G--Cholecystitis	ICD-9-CM code 574.6x does not exist; code range should be **574.5x-574.8x**
Effectiveness of Care	Treating Children's Ear Infections	52	Table 1G--Cholecystitis	ICD-9-CM code 575.1x should be **575.1**; there are no 5th digits for the 575 series
Effectiveness of Care	Eye Exams for People with Diabetes	56	First Bullet	ICD-9-CM code **648.0x** should be listed as a diagnosis of diabetes; it was erroneously left out of the final.
Satisfaction with the Experience of Care	Member Satisfaction Survey	102	Sample Frame	The sample should include only current health plan members **who were** age 18 years and older **as of December 31 of the reporting year,** who have been continuously enrolled for the twelve months of the HEDIS reporting year. Continuous enrollment allows for one break of up to 45 days.

Correction Sheet for HEDIS 3.0 January 1997				
Domain	**Measure**	**Page Number, final *HEDIS®* 3.0, *Volume 2***	**Location**	**Correction (in Bold)**
Use of Services	Well-Child Visits in the First 15 Months of Life	131	Administrative Data Spec - Denominator	The following language should be added: For each population...Members who have had no more than one break in enrollment of up to 45 days **during the continuous enrollment period** should be included in this measure.
Use of Services	Well-Child Visits in the First 15 Months of Life	133	Hybrid Method Spec - Denominator	The following language should be added: For each population...Members who have had no more than one break in enrollment of up to 45 days **during the continuous enrollment period** should be included in this measure.
Use of Services	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	134	Administrative Data Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year **and who were members of the plan as of December 31 of the reporting year**.
Use of Services	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	135	Hybrid Method Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year **and who were members of the plan as of December 31 of the reporting year.**
Use of Services	Adolescent Well-Care Visits	137	Administrative Data Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year **and who were members of the plan as of December 31 of the reporting year.**

Correction Sheet for HEDIS 3.0 January 1997				
Domain	**Measure**	**Page Number, final *HEDIS® 3.0, Volume 2***	**Location**	**Correction (in Bold)**
Use of Services	Adolescent Well-Care Visits	138	Hybrid Method Spec - Denominator	The following language should be added: Two separate denominators,...who were continuously enrolled during the reporting year **and who were members of the plan as of December 31 of the reporting year.**
Use of Services	Frequency of Selected Procedures	149	Notes	The following note should be added: **Angioplasties or cardiac catheterizations performed in conjunction with (i.e., on the same date of service as) a coronary artery bypass graft should not be counted in the angioplasty or the cardiac catheterization rate; count only the coronary artery bypass graft.**
Use of Services	Frequency of Selected Procedures	152	Table 5C-3	The table asks for Total member months for males and females age <65, 65-74, 75-84 and 85+. Total member months are <u>not</u> used in this table; each procedure is reported separately by sex.
Use of Services	Mental Health Utilization - % of Members Receiving Inpatient, Day/Night Care and Ambulatory Services	192	Algorithm for identifying inpatient, day/night and ambulatory services - Instructions.	Separate the CPT-4 codes...Revenue code (Form Locator 42): 912 (Psychiatric/psychological services-partial hospitalization) **or 913 (Psychiatric/psychological services-night care)**

Correction Sheet for HEDIS 3.0 January 1997				
Domain	**Measure**	**Page Number, final *HEDIS®* 3.0, *Volume 2***	**Location**	**Correction (in Bold)**
Use of Services	Chemical Dependency Utilization - % of Members Receiving Inpatient, Day/Night Care and Ambulatory Services	205	Algorithm for identifying inpatient, day/night and ambulatory services - Instructions.	Separate the CPT-4 codes...Revenue code (Form Locator 42): 912 (Psychiatric/psychological services-partial hospitalization) **or 913 (Psychiatric/psychological services-night care)**
Health Plan Descriptive Information	Preventive Care and Health Promotion	237	Specifications - step 1.	For each population...identify the health promotion/education programs provided by your health plan and the number of members who participated in each program during the **reporting year.**